20 MAY 2000

CHEMIST & DRUGGIST

THE NEWSWEEKLY FOR PHARMACY

PSNC threatens to go public over generics

Smoking cessation schemes aim at wider audience

Appelbe tops RPSGB Council election

Michael Ward seeks more co-operation with independents

Moss acquires 57 Scholl stores for £3m

Update: drugs that deal with migraine

Online at http://www.dotpharmacy.com/

Rennie Duo - Product Information. **Uses**: Symptomatic treatment of complaints resulting from gastro-oesophageal reflux and hyperacidity. **Presentation, dosage and administration**: Oral suspension: Each 10ml (1 dose) of suspension contains: 1200mg calcium carbonate, 140mg magnesium carbonate and 300mg sodium alginate. Note. As well as the mechanical barrier to acid reflux provided by the alginate, the combination of two antacids provides a total neutralising capacity of 32mEq/H+. The usual dosage is 10ml to be taken after meals and before retiring. In cases of reflux an additional dose of 10ml may be taken between normal doses to a maximum total of eight unit doses in 24 hours. Recommended in adults only (above 12 years). **Side effects and precautions**: When used normally at the recommended dosage no undesirable side effects are expected. As with all antacid combination medicines caution should be exercised in patients with impaired renal function; prolonged use of high doses can result in hypermagnesaemia, hypercalcaemia or alkalosis especially in this group and plasma calcium and magnesium levels should be monitored. Prolonged use possibly enhances the risk of development of renal calculi. 10ml Rennie Duo contains 120mg sodium, which should be considered for patients on a restricted sodium diet. As with other antacids Rennie Duo can mask the symptoms of gastric malignancy. In patients also taking antibiotics it is advisable to recommend that Rennie Duo should be taken 1-2 hours after their other medicine. Rennie Duo, if taken as recommended is not hazardous to either foetus or infant during pregnancy or lactation. **Contra-indications**: Rennie Duo should not be used in patients having severe renal insufficiency, hypercalcaemia or hypophosphataemia nor in patients with nephrolithiasis or a known hypersensitivity to any ingredient. **Product licence number**: PL00031/0518. **Supply Classification**: GSL restricted to pharmacy only. Rennie is a registered Trade Mark. Packs and Prices: 50ml £0.84 (ex VAT), 180ml £2.88 (ex VAT), 500ml £4.37 (ex VAT). PL holder: Roche Consumer Health, 40 Broadwater Road, Welwyn Garden City, Herts., AL7 3AY. **Date of revision**: August 1999.

Roche

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CHEMIST & DRUGGIST

THE NEWSWEEKLY FOR PHARMACY

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REGULARS

COMMENT

A one-stop shopping experience is a familiar motto of supermarkets. Major pharmacy multiples see the commercial sense in this strategy, which is why they are beginning to offer customers a one-stop healthcare experience. Moss Pharmacy's acquisition of 57 Scholl outlets is the latest example. The chain already has chiropodists in some stores, and it can now offer far more extensive chiropody and footcare services through Scholl. It can also use its marketing expertise to expand Scholl's 10 per cent stake in the £300m-£500m chiropody/footcare market. Boots The Chemists is trialling in-store chiropody practices; and it is involved in dentistry and specialist skincare consultations. Lloydspharmacy is taking a holistic view of healthcare through its health and well-being centre. Such moves make sense: the longer customers spend in a store the more likely they are to buy something on impulse. However, Moss *et al* are probably more interested in changing how customers perceive pharmacies. Many independents are suffering because most customers see them as corner shops that dispense prescriptions and are good for the occasional 'distress' purchase. The Government says it values pharmacy, but its lack of concrete help suggests that it also has that misconception.

Multiple pharmacies are investing to prove that their healthcare interests run deeper than that. Some do not mind sharing their expertise with independents. Moss could offer them 'mini Scholl areas, if they prove successful in its own outlets. And Lloydspharmacy is willing to join forces with independents to bid for primary care contracts. Independents should take advantage of these opportunities: if the ultimate aim is to change the public's image of pharmacy, every one wins.

Editor Patrick Grice, *MRPharmS*
Assistant Editor Guy L'Amable, BA
News Editor Charles Gladwin *MRPharmS*
Contributing Editor Adrienne de Mont *MRPharmS*
Beauty Editor Sarah Thackray
Reporter Steven Bremer *MRPharmS*
Art Editor Tony Lamb
Production Editor Vanessa Townsend, BA
Editorial secretary Jan Powis
Editorial (tel): 01732 377487; (fax): 01732 367065
E-mail: chemdrug@unmf.com
Price List
Colin Simpson *(Controller)*
Darren Larkin, Maria Locke
Price List (tel): 01732 377407; (fax): 01732 377559
Group Advertisement Manager
Julian de Bruxelles
Group Advertisement Executives
Simon Goddard, Christian Harris, Sophie Wellsted
Classified Executive
Matthew Goold
Advertisement department secretary
Elaine Steele
Advertising (tel): 01732 377621; (fax): 01732 377179
Production
Karen Way
Associate Publisher
John Skelton *FRPharmS*

Chemist & Druggist incorporating Retail Chemist, Pharmacy Update and Beauty Counter

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Tel: 01858 438893
Fax: 01858 434958

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'Reckless' Government faces generics backlash

The anomalies

PSNC analysed the DoH's list of generic drugs and its main finding is that prices quoted by the DoH, which are meant to correspond to the average Drug Tariff prices for November 1998 through to January 1999, show several anomalies. Among these are:

- 58 maximum prices matched those of the March 2000 Drug Tariff since those prices were lower than the November 98-January 99 average
- of the 478 maximum prices given, 27 were not identified as DT Part VIII entries and were not listed in 1998
- there are 11 items on the list which have a maximum price which does not equate to rules set out by the DoH
- 130 maximum prices were calculated pro rata from a larger pack size

The Pharmaceutical Services Negotiating Committee is considering a publicity campaign to blame the Department of Health should there be generics shortages.

In a stiffly-worded letter, PSNC has attacked the Government's unilateral proposal to abolish Category D of the Drug Tariff without putting any revised arrangements in their place. PSNC is "amazed" at the Department of Health's confidence in the generic suppliers to meet the needs of the market place.

The reduction in generics pricing will take effect in July, with the reimbursement in place for prescriptions dispensed from August 1. PSNC says it has no alternative but to advise pharmacy contractors to run down stocks of generics bought at the higher prices so they will not face too great a financial loss when the new arrangements come into force.

But in its letter to the DoH, PSNC warns that "failure by NHSE to address this issue in a sensible manner by providing arrangements for genuine shortages will mean that the Committee will have no alternative but to embark upon a high-profile campaign involving the public, Parliament, the professions and health authorities to make it very clear to patients that the PSNC had both anticipated shortages and warned NHSE of the consequences of its reckless decision".

PSNC says it will not be prepared to accept any blame for the consequences of the Government's action and accuses NHSE officials of an "apparent inability to appreciate that there will be genuine shortages".

The Committee is demanding an indemnity from the NHSE on behalf of contractors. This would protect against any action taken by patients who may be unable to obtain medication due to the removal of the arrangements that currently allow pharmacists to take action to mitigate shortages.

Compensation must be paid to pharmacy contractors against any financial losses incurred as they will inevitably have to source stock at higher prices to ensure continuity of supply to patients.

"We consider that the only feasible option is for contractors to be permitted to endorse the preparation supplied and receive appropriate reimbursement," it says. The only alternative would be to refer the patient back to the prescriber to rewrite the prescription for a branded product. This would conflict with the DoH's insistence not to reconsider the terms of service with regards to supplying a medicine with reasonable promptness.

PSNC has also rejected a suggested offset to the discount scale allowing a retrospective readjustment. This was unacceptable because of its arbitrary and impractical nature.

No special reimbursement for generics, warns minister

Pharmacists in England cannot expect any special arrangements to reimburse them for stocks of generic medicines bought under the current pricing regime. In addition, normal prescription payment arrangements are unlikely to return until September 2001, a health minister has said.

In two written answers this week, Gisela Stuart set out the procedures expected for both the introduction of the new generics medicines pricing scheme and the Prescription Pricing Authority payment schedule.

Referring to the generic pricing structure, Ms Stuart said that the proposals to set maximum prices for generic medicines aims to protect the NHS by correcting the effect of last year's price increases. This would also allow "reasonable returns" to those in the supply chain.

Ms Stuart was asked more specifically if pharmacists would be reimbursed for stocks of generic medicines bought under the old pricing regime. She responded: "Community pharmacists, along with other parties in the supply chain, have several months in which they can reduce their stockholdings before the proposed legislation requiring price cuts takes effect.

"In addition, reimbursement prices will not be brought into line with the new selling prices until the following month, thus providing a further time interval during which stocks can be run down and replaced with new stock at the lower price."

For prescription reimbursement, the PPA is making balancing readjustments to convert interim payments to pharmacists to payment of actual costs three months later than normal, she said. Forecasts indicate this delay will reduce to two months by February, 2001. Normal payment arrangements should resume from September 2001.

RPSGB defuses flat purchase row

The Royal Pharmaceutical Society Council has agreed to complete the purchase of a £600,000 apartment, despite the purchase process having a number of "flaws".

However, a call to name the persons responsible for buying the flat without the Council's full knowledge or approval was rejected at the Society's annual general meeting.

Shortly before the meeting, the Council met to discuss the purchase and agreed to complete it, both as an investment and to support plans to refurbish the Lambeth headquarters.

The Council had agreed at the meeting to take forward a project looking at ways to reverse the decline in value of the headquarters and to make best use of the premises as a working environment. Council has not committed itself to any part of the proposal but will set up a steering group to consider options.

Proposing the motion, Anthony Cox said the problem lay with the process and accountability, rather than the purchase itself: council should have given full approval before the purchase was made, he said. "We wish to know who was responsible, and why Council was bypassed."

Before the meeting, the Society distributed an explanation of events leading up to the flat's purchase. This referred to a "number of procedural flaws that raise concerns about the processes of the Society". The council will address those flaws and put "robust" systems in place in the future.

The flat purchase was part of broader plans to modernise the Lambeth headquarters. Surveyors have informed the society that the Lambeth headquarters has lost considerable market value – "several million pounds" – and should be refurbished.

Former president, Nicholas Wood, said a mistake had been made in the decision to buy the flat, but an apology had been made.

"This motion appears to turn this whole thing into a witch-hunt," he said. "Here we are, navel-gazing once again." Instead, attention should be paid to the wider range of issues the society has to deal with.

Mike Burden added: "There are a host of issues which should be occupying members. Maybe they could have communicated more effectively, but we have a decision and should accept the sentiment of the briefing document."

Society wants sharper EHC policy to drive reforms

President of the Royal Pharmaceutical Society, Christine Glover, has suggested that its Council should clarify its policy on the supply of emergency hormonal contraception.

It should be made clear that the Society wants pharmacy access both by reclassification from 'POM to P', and by instituting measures to ensure that EHC was available free to those unable to pay. How to get to that position should not be part of the policy, but could be part of a debate with Government, suggested Privy Council member, Mrs Terri Banks.

The Council reaffirmed its policy that it is in the public interest to improve access to EHC through community pharmacies at its meeting last week. The Council made its decision after considering two documents, one prepared by the Society's Policy Support Unit, the other prepared by Hemant Patel.

The PSU paper stated that the Government does not intend to restrict Levonelle-2's availability through other routes if it becomes a P medicine; and availability by other routes is likely to increase, regardless of whether it is deregulated.

Opposition to a 'POM to P' switch would be inconsistent with the Society's wish for the extension of prescribing powers to pharmacists. Widespread, successful provision of EHC as a P medicine would provide a good foundation for arguing that pharmacists should be given prescribing powers.

But there is a danger that if pharmacy opposes deregulation of Levonelle-2, the Government will use other means, and other health care professionals, to improve access to health care.

Mr Patel's paper set out a number of perceived disadvantages in the supply of EHC as a pharmacy medicine. These included having to pay for the product, and the comparative difficulty of measuring health-gain in the absence of any formal recording system.

Advantages of a group protocol system included data-capture of patient, drug and area information for sharing in the NHS, and demonstrating the benefits of including pharmacy within the NHSnet.

Space audit The Council agreed to investigate a proposal for upgrading the Society's headquarters building. The proposal involves filling in the L-shape of the building above the ground floor and adding a sixth and seventh floors to increase the building's capacity by 70 per cent.

Options proposed by Andrew Smith, of LSM Partners property advisers, included the following:

- a limited upgrade of parts of the building, which would be a short term solution lacking flexibility
- the winter garden scheme would provide an excellent building for current needs, but would be inflexible in use and not retain its value for long
- the forum scheme would produce a flexible, design-led ideal building. This scheme would cost £14 million.

A steering group will be set up to consider the proposal, and planning application, in detail.

Internal audit The Council approved a proposal that the Society should establish an immediate internal audit, separate and distinct from its external audit, under an audit committee.

Pharmacy group seeks nationwide EHC

The All-Party Pharmacy Group is to call for pharmacy supply of emergency hormonal contraception to be extended nationwide.

At a meeting on EHC at the Houses of Parliament on Tuesday, APPG chairman Howard Stoate MP said the aim was to move the debate forward. "This issue will not go away. We now have to make sure the service is rolled out nationally," he said, adding that limited availability would constitute post-code prescribing.

APPG will write to health ministers about the progress of pharmacy supply of EHC. The letter will also ask for clarification on the legal position of such services. Although nurse practitioners have been supplying EHC, some health authorities' legal advice is scuppering pharmacist supply, the meeting heard.

Project manager for the Manchester scheme, Karen O'Brien, and pharmaceutical adviser, Melanie Ogden, reported on its success. Since December 24, 1999, the Manchester scheme has had 1,424 requests for EHC. Of these, 111 fell outside the protocols and were referred to other family planning services.

Clients ages ranged from 14 to 56. Almost half the clients came because of burst condoms, 11 per cent because they forgot to take regular hormonal contraception.

Referrals come equally from NHS Direct, GPs and by word of mouth. Only one per cent were referred by A&E.

BMA practice committee chairman John Chisholm supported the scheme: "I would very, very strongly welcome this initiative."

A fuller report of the meeting will appear in next week's *C&D*.

Pharmacies playing key role in anti-smoking campaign

A smoking cessation campaign through pharmacies attracted a high proportion of people who had never tried to give up smoking before.

More than 400 customers asked for advice at 18 pharmacies in Ealing, Hammersmith and Hounslow, during a four-week campaign coinciding with national No Smoking Day on March 8. Two-thirds of the smokers had never previously sought advice or tried to quit.

The 21 pharmacies received £65 each and the 26 assistants £20 each for attending an evening training session on smoking cessation; and pharmacies were given £300 at the end of the project.

The campaign began on February 21 with a week's pre-window display phase; then, for three weeks, the pharmacies displayed a smoking cessation poster in the window and filled in a log book when dealing with customers. Pharmacy staff also completed pre- and post-campaign evaluations.

'Action taken' was recorded for 434 customers, of whom 47 per cent bought nicotine replacement therapy; 30 per cent took leaflets; 27 per cent were given information on NRT; and eight per cent took health promotion advice. 'Other action', involving seven per cent, included referral to support groups or other health professionals.

Just over half the pharmacists took less than two minutes to give advice; the rest took longer. There were more female customers than men and 82 per cent were white. Thirty-five per cent were taking prescription medication or had one or more medical conditions – most commonly, high blood pressure, followed by asthma and angina.

Sangeeta Sharma, pharmaceutical advisor to EHH health authority, said the study showed that pharmacists can play a positive role in smoking cessation, particularly as many smokers were willing to try pharmacies when they had not tried to give up smoking before.

The next step would be to ensure that pharmacies were involved in local health promotion strategies, and in the smoking cessation clinics being set up with new government money.

Ms Sharma said pharmacies should have access to sources of information and referral services and be encouraged to advise people trying to quit, and pharmacists who undergo smoking cessation training should be accredited.

Among the pharmacy profession's 21 new fellows this year were two with close links to *Chemist & Druggist*. John Skelton is a former editor of the magazine and is now associate publisher. Mary Allen is a regular contributor to both Pharmacy Update in *C&D* and to *Over The Counter*, for pharmacy assistants. Both were awarded the fellowship for distinction in the profession of pharmacy. Ms Allen and Mr Skelton are pictured with their certificates after being presented with them by president Christine Glover at the Royal Pharmaceutical Society's 159th AGM (see p5)

Prescribing advice pays off, literally

Fourteen community pharmacists are giving prescribing advice to nearly all GP practices in Walsall, after a study showed that pharmacists could improve prescribing standards.

Six pharmacists worked one day a week in a GP practice for one year during 1997-98, concentrating mainly on improving the prescribing of non-steroidal anti-inflammatory drugs.

They reviewed elderly patients taking four or more medicines and, if one was an NSAID, decided whether to intervene according to criteria agreed with the eight practices involved. This could mean reducing the dose, discontinuing the drug, changing to a better tolerated drug, and introducing or stopping ulcer therapy.

The pharmacists were paid £200 a day by Walsall Health Authority. The effects were measured by PACT analyses and interviews with GPs and patients.

Health authority pharmaceutical adviser, Nigel Barnes, who led the project, said: "Some GPs were apprehensive initially, but by the end of the year they accepted the pharmacists' input and wanted it to continue. Other GPs wanted to join the scheme." The patients were also happy with the pharmacists' interventions.

He estimates that the pharmacists helped save at least £25,000, although it was a quality-raising rather than cost-cutting exercise. "We instructed them to save money where appropriate, or spend more if that was appropriate."

The results suggested that, where medication changes were proposed, a face-to-face consultation or telephone call were more successful than a letter.

The primary care groups are now paying for pharmacists to continue the work. Some are giving prescribing advice on two or three days a week and one pharmacist is about to go full time.

Appelbe tops Council poll

Gordon Appelbe has come first in this year's election to the Royal Pharmaceutical Society Council.

Dr Appelbe is currently the Society's treasurer. He has been returned to council with the other three council members seeking re-election, Peter Curphey, Linda Stone and Hassan Argomandkhah. The three new faces to join Council are Alison Ewing, Kirit Patel – former chairman of the National Pharmaceutical Association – and Nicola Gray.

The electoral response was typically low, with only 19.6 per cent of the 43,205 pharmacist members returning ballot forms. Of the 8,480 envelopes returned, 68 were not opened as they were unsigned; and a number of other ballot forms were found to be invalid because they were either blank or spoilt.

Alison Ewing

Kirit Patel

Nicola Gray

The order in which the candidates were elected is as follows:

Gordon Appelbe
Alison Ewing
Kirit Patel
Peter Curphey
Nicola Gray
Linda Stone
Hassan Argomandkhah.

The election for the officers of the Society will take place at the next full Council meeting on June 7.

PSNC rejects pay offer as morale slumps to an all-time low

The Pharmaceutical Services Negotiating Committee has unanimously rejected as "totally inadequate" the pay offer from the NHS Executive for 2000-01.

PSNC chairman Wally Dove also warned that the situation is posing a serious threat to future pharmacy services.

"The general feeling of the committee was that we have been hit over the head so hard, so often, that morale is at an all-time low in all parts of the contractor profession, whether employer or employee, or large or small store.

"There are increasing signs that it is starting to affect future investment plans in community pharmacy and it's about time NHSE woke up to that fact," Mr Dove said after the committee met last week.

PSNC is to send a detailed response to the NHSE arguing that an improved offer is justified.

Discount enquiry PSNC has persuaded the Department of Health to put this year's discount inquiry back until the autumn, in light of the current situation regarding category D and changes to generic pricing.

NHS modernisation PSNC and the NPA have agreed to co-ordinate their response to the Prime Minister's challenges to modernise the NHS.

It is likely that the Company Chemists' Association will support the response to ensure that contractor organisations put forward the same views.

While PSNC sees the government's consultation as a unique opportunity to promote community pharmacy, it is concerned at the short timescale allowed for responses.

"It's another example of the government doing something whizzy," said Mr Dove. "They probably know the result and this is just window-dressing." However, he is still encouraging community pharmacists to respond.

Domiciliary oxygen PSNC has agreed with the NPA to send a joint response to the DoH's consultation on domiciliary oxygen services. The CCA has already responded, but is supporting elements of the PSNC/NPA report.

More ways to help patients through IT

Digby Emson

NHS Direct programmes, or something similar, could be in every pharmacy to guide professional consultations and improve links with other healthcare providers.

Boots pharmacy superintendent Digby Emson was to put this, and other ideas for IT developments in health care, to a meeting on 'Consumer sovereignty' on Wednesday, after *C&D* went to press.

"There is little evidence that telephone services alone – useful though they may be – can substitute for the face-to-face personal care and support that people from all social backgrounds obtain from both pharmacies and general practices," said Mr Emson.

He also suggested that giving people more direct authority over their own electronic medical records was fundamental to NHS modernisation. Patients should be able to decide who saw their medication and other records, and who used them to provide the best access to treatment.

A central computer database could be accessed, on the patient's authority, from the hospital, surgery, pharmacy or NHS walk-in centre, or by other properly qualified and accountable people. The information should be sufficient to understand the patient's medical history and current treatments. Health professionals would update the record whenever a consultation, test or treatment took place.

From a pharmaceutical care perspective the benefits of being able to receive prescriptions electronically, check against previous medication and contra-indications, and give the patient informed advice would be significant.

Boots uses virtual psychology to make smokers quit

Boots the Chemists is rolling out a free computerised smoking cessation programme which works by creating behavioural change in smokers.

The Pro-Change Programme has been piloted in Northumberland and the south east. Boots intends to make the system available in 200 pharmacies across Britain by October, with further expansion after that.

Pro-Change is an interactive computer programme aimed at smokers who are beginning to think about giving up, and for people who have given up but want support. Trained pharmacy and healthcare staff offer additional advice.

Success rates in helping people to quit vary from 18 to 25 per cent, says Boots.

A session takes up to half an hour, with about 20 minutes spent by the user going through the programme. This gets the smoker to think about their reasons for giving up smoking, the benefits, ways to cope with other people's behaviour and how to deal with smoking urges. At the first session, quitters indicate at which stage they are in the process of trying to give up smoking. The computer's response gives smokers a path to follow at their own pace.

Although Boots has brought Pro-Change to the UK and holds the licence for the adult smoking programme, it will also make the licence available to health authorities and health action zones. These will be able to install Pro-Change at suitable sites such as non-Boots pharmacies or GP surgeries. Other programmes have been designed for pregnant mothers and teenagers.

Pro-Change is based on the trans-theoretical health behaviour model, developed in the US by Prof James Prochaska at the University of Rhode Island. Longer term, it may be possible to adapt the system to help tackle addictions to alcohol or overeating.

INDUSTRY VIEWPOINT

Is it time for a new super-P system?

It is 17 years since loperamide became one of the first 'POM to P' switches. Over the years, scores of ingredients have passed down the same route and numerous new P products made available to pharmacy. In the past few years the number of ingredients switching has slowed to a trickle and some feel the stream has almost run dry.

With innovation as the lifeblood of any business, and especially healthcare, what will be the driving force for innovative pharmacy medicines?

Attention is turning to collaborative care models, where members of the primary healthcare team – GPs, nurses and pharmacists – work together to provide better care to patients, following an agreed model.

Several test environments are well established and, in most, the patient has a known illness that often needs prescription medicines.

But consider collaborative care models that target conditions rather than illnesses, and how these could be controlled and even prevented. Such conditions include raised cholesterol levels, sexual dysfunction, osteoporosis, male pattern baldness and influenza. Some of these have been termed 'lifestyle conditions' and, while effective products are available, they may not be NHS-reimbursed.

"Reality also means that the profit motive has to be considered"

Is the answer the creation of a super-P category where pharmacists may sell such products within a collaborative care system? Without doubt, many individuals would be willing to pay for access to these products.

There are many factors to consider. How can the average pharmacist develop the knowledge and skills to fulfil their role in the model system? The same applies when pharmacists take control of repeat-prescribing.

Spending most of your time in the dispensary is not the future. Being available to the public – using your knowledge and skills – is where the successful pharmacist of the future will be found.

So what's in it for pharmacy? Increased professional involvement and satisfaction. But reality also means that the profit motive has to be considered.

Contributed by a senior industry manager.

Xrayser

Topical Reflections

Central filling of repeat scripts may cross the pond

News from the USA (*C&D* May 13) provided a fascinating and thought-provoking insight into the technological advances being introduced for centralised dispensing and automated delivery of prescriptions.

It is difficult to compare the UK with the US because the health care systems are fundamentally different. However, in the US, the electronic systems which seemed to encourage the expansion of mail order and internet dispensing and so threaten the existing network of community pharmacies, may now be used to reinforce the advisory role of the pharmacist in the community.

The centralised dispensing of repeat prescriptions, with daily delivery to the community pharmacy of the patient's choice, which could soon become a reality in the US, is just as feasible for this country. The technical dispensing function would be left to an efficient centralised pharmacy facility, while the monitoring, dependant prescribing and counselling functions would take place in community settings.

Centralised dispensing could help replace the present unproductive pressures of single-shop repetitive dispensing. But the direct pharmacist-patient consultation must remain the gold standard practice norm for all community pharmacists.

Truth-massage is the norm, but is it acceptable?

The Consumers Association has quite rightly criticised babyfood labels for their meaningless claims (*C&D* May 13, p14), but babyfoods are not the only culprits. Spurious claims and superlatives permeate the labels of most of the products that I sell – and that includes medicines – to the point where a degree in interpretive English is required by the consumer to make any rational choice.

Where the Consumers Association is right is that these labels are misleading and can be potentially damaging to the consumer. But what is not highlighted is that there are few regulatory controls over information that cannot be danced round by the script writers.

It must also be true that this is an area of consumer protection that is almost impossible to regulate. So perhaps a different approach should be adopted: perhaps complaints about meaningless or misleading label information could be made to an adjudicating body which would be given powers to require change – or even to withdraw a product for re-labelling.

Certainly words like *new*, *extra*, *may*, *strong*, *natural* and *fresh* are all open to abuse – but also acceptable in the correct context. Nothing should be circumscribed, but the penalty for a complaint upheld should be made very clear, and very expensive. Perhaps manufacturers would then be more careful how they labelled their products.

Time to cut back on generic stocks

It has not taken long for generics manufacturers to react to the Government's threat to regulate prices. The first to do so – and in dramatic style – has been Norton, which has suddenly discovered enough manufacturing flexibility to drop a basket of prices, including thyroxine, to below the magic November 1998 figure.

However, no amount of tele-sales talk of special 'advantage' will make me buy because I, too, have seen the writing on the wall. The past 18 months of generic chaos has forced me to raise my stocks higher than I am used to in order to cushion me from sudden shortages.

But prices are plummeting and I must drop my stock to the more realistic level of that of – yes, you've guessed it! – November 1998. So now I am actively de-stocking. Norton has dropped its prices; others in the industry will follow.

The resulting blood-bath will not be pleasant but may enable the Government to say: "We told you so!" And then accept a reasonable voluntary compromise, delaying the proposed reference price imposition. This must, ultimately, be good news because a stable market is what I really desire.

This still leaves an alternative to Category D to be found. It cannot be unilaterally abolished without first agreeing a workable replacement. I need the regulatory reassurance of knowing that the prices I have to pay to satisfy my obligations to the patient will be fully reimbursed.

This should be achieved by reasonable negotiation with PSNC – and not by the naïve belief that a statutory maximum price for the generic product will somehow magically guarantee sufficient supply.

CPPE's new web site will be interactive

The Centre for Pharmacy Postgraduate Education has launched its web site at *www.cppe.man.ac.uk*.

Among the contents on the site are listings of activities, courses, tutors, advice on how to assess learning needs, and details of the Continuing Professional Development Award.

Future developments are likely to include on-line interactive learning material, a section providing tutors with administrative support for running courses, and a personalised entry for all pharmacists. This will allow pharmacists to check on CPPE activity, and to book courses.

New team to help RPSGB members

The Royal Pharmaceutical Society has started to build its new membership services team, led by Amanda King of the public relations division.

Public affairs director Beverley Parkin hopes that bringing together membership and public relations will improve the quality of service, particularly to the branches and regions. More staff are being recruited to bring the team up to full strength and a members' inquiry helpdesk should be operating by late summer.

Ms Parkin said the team would "respond to inquiries courteously, efficiently and effectively; and look for new ways of improving our services".

NPA roadshow sets off on Monday

Junior health minister Gisela Stuart will launch the National Pharmaceutical Association's 'Ask your pharmacist' roadshow on Monday.

Ms Stuart is scheduled to cut the ribbon on the roadshow trailer in Covent Garden, London, at 11am. The public venues for the rest of the week are:

Tuesday – St Albans
Wednesday – Chelmsford
Thursday – Maidstone
Friday and Saturday – Lewisham.

NPA members' evenings will take place on each Friday of the six-week tour. The first evening will be held at the Hilton Hotel in Purley Way, Croydon, on May 26 and Andrew McCoig will be the guest speaker.

The roadshow trailer will show the the work community pharmacists are involved in. There will be an area for health enquiries, as well as street theatre, giveaways and competitions. Members who would like to attend the events should contact the NPA on 01727 858687, ext 265, 340 or 311.

Computer strategy sought

The Royal Pharmaceutical Society's Practice Committee is to look at ways in which the society could work with other stakeholders to influence the strategic development of pharmacy computer systems. A proposal will be prepared for a future meeting.

The committee also agreed, at a meeting on May 2 that the Society's guidelines on computer systems, published in *Medicines, ethics and practice*, should be updated and reviewed every six months.

Standard operating procedures The pharmacy sector committee of the Science, Technology and Mathematics National Training Organisation has set out draft principles for standard operating procedures (SOPs) for dispensing in pharmacies.

The Practice Committee thought it would be impossible to develop a 'one size fits all' SOP and that there should be a set of guiding principles based on key elements of the dispensing process. Council had already agreed that, as a step towards ensuring clinical governance, all pharmacies should put written SOPs in place; and the society should work with the pharmacy sector committee, on which major employers of pharmacists are represented.

Medicines management The Practice Committee agreed to seek an update on the medicines management project, led by the Pharmaceutical Services Negotiating Committee, once the Department of Health has replied to the funding bid.

'Peppermint water' case The Education Committee identified several points for consideration in the office's review of the implications for pharmacy education and training of the death of a baby following a mistake in dispensing peppermint water.

Domiciliary oxygen review The society's response to the Department of Health's review of the domiciliary oxygen service in England will point out that community pharmacies have an advantage over other potential suppliers.

They could provide a responsive and integrated local service, with advice on other medicines.

Working with industry The Practice Committee approved for publication a document offering guidance to pharmacists whose work brings them into regular contact with the pharmaceutical industry. The document will cover meetings with representatives, sponsorship and the industry's code of practice.

Complementary medicine Fact sheets on aromatherapy and herbal medicines will be considered by the working group on complementary medicine at its next meeting.

More fact sheets are being prepared on interactions of herbal with allopathic medicines, on homeopathy, and on dietary supplements. They will eventually be provided to pharmacists to help in dealing with inquiries from the public.

BA Festival The Science Committee agreed that the society should submit a bid to run a session on 'Cannabis as a medicine' at the 2001 Festival of Science in Glasgow in September, organised by the British Association for the Advancement of Science.

MCA clears contraception advice

The Medicines Control Agency has rejected a complaint that a leaflet on contraceptive options was advertising prescription-only medicines.

The British Pregnancy Advisory Service leaflet suggests women can be prepared for the unexpected by keeping after-sex contraceptive pills to hand. The leaflet promotes the availability of emergency hormonal contraception from BPAS doctors with the slogan: "It's your future, it's your life, it's your choice – be prepared for the morning after."

In its decision, the MCA accepted that the leaflets were designed to increase awareness of the availability of emergency contraception. The MCA noted that it "does not seek to restrict access to information", and added that the issue of unwanted pregnancies is a priority for the Department of Health.

The MCA said the material in the leaflet "appears to be factual and health educational and is therefore not in breach of the Advertising Regulations".

The BPAS was "amazed" when the complaint was made, said a spokesman. "The leaflet does not promote any specific product and so cannot be said to be advertising one."

Besides promoting the BPAS service, the leaflet said that emergency contraceptive pills are not as effective at preventing pregnancy as regular contraception; nor did they protect against sexually transmitted disease.

Famotidine poised for GSL

The Medicines Control Agency is proposing to add famotidine to the General Sales List.

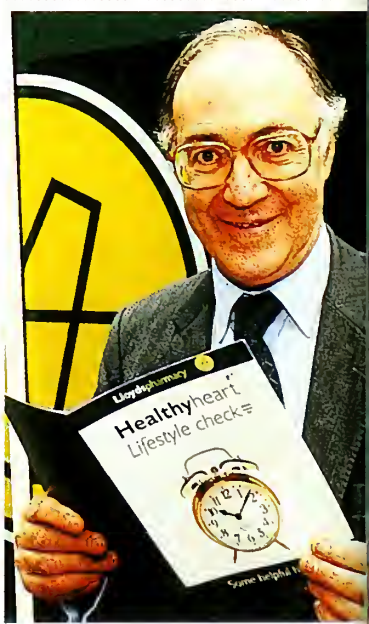
In its consultation document, MLX 262, the MCA proposes to put famotidine on the GSL for the short-term symptomatic relief of heartburn, indigestion, acid indigestion and hyperacidity.

The maximum dose would be 10mg, and the maximum daily dose 20mg. Pack size would be restricted to a maximum of 12 tablets.

The MLX also proposes that bisacodyl be GSL-listed in packs of 20 tablets, subject to the addition of a patient information leaflet specifying a maximum length of treatment of five days.

It also plans to add heparinoid for external use to the GSL – with a maximum strength of 1 per cent – for the relief of bruises, sprains and soft tissue injuries in adults and children over six years old. The maximum pack size would be 20g.

Alpha-pinene for external use has also been proposed for addition to the GSL. It is the main constituent of turpentine oil and is found in other essential oils including juniper and rosemary. Subject to approval, the MCA plans to implement the changes by September.



Former Home Secretary and Folkestone and Hythe MP Michael Howard had a Healthyheart Lifestyle Check at a Lloydspharmacy in his constituency earlier this month. Lloydspharmacy is increasing the number of pharmacies offering the screening test, in which pharmacists use a computer to analyse factors including blood pressure, cholesterol and lifestyle. This produces a rating indicating the general health of the heart

We've given Witch Doctor the treatment.

Introducing the new Witch range of skincare products.
We've taken all that's good about Witch Doctor...and made it even better. You can recommend proven, effective products with the cleansing and soothing qualities of natural witch hazel. And we have big plans for Witch in the future, so you'll be able to offer an even wider Witch range when we introduce more exciting new products. So make sure you place your order for the Witch range today. With a heavyweight £2m advertising and PR launch behind it, we're expecting quite a demand!

Witch. Strong in spirit. Gentle on skin.

Witch Stick. Cleansing & Toning Pads.
Skin Treatment Gel. Lotion. Sun Sore Soothing Gel.

Renaming
Witch. The new name for Witch Doctor

Repackaging
Eye-catching new packaging

Reinvesting
Heavyweight £2m advertising and PR launch

Remarketing
New products, new profit opportunities

WITCH™
with Natural Witch Hazel

Customers on tap

Stand by for the latest sensation in OTC medicine – an oral pain reliever that melts in the mouth without water! There's never been a sales opportunity like it.

New Nurofen Meltlets contain ibuprofen in a unique formulation that dissolves quickly on the tongue with a pleasant lemon taste. They offer maximum convenience to all your customers on the road, at work, or out and about, who find themselves in need of pain relief but nowhere near a tap!

no water required

new

Pain Relief ***On The Go***

Script specials

Inhaled corticosteroids advocated for COPD

New research suggests that Fluticasone propionate slows the decline in health and reduces the number of exacerbations in patients with moderate to severe chronic obstructive pulmonary disease.

The inhaled steroids in obstructive lung disease in Europe study (ISOLDE) was designed to test the effect of inhaled fluticasone propionate, at 500mcg twice daily, on the rate of decline of forced expiratory volume in one second (FEV_1), and other clinical outcomes. The study, published in the *British Medical Journal*, looked at 751 current or former smokers with a mean FEV_1, or approximately half that expected.

Patients were randomised, receiving either fluticasone via metered dose inhaler and spacer, or placebo. Patients were provided with salbutamol or ipratropium bromide for symptomatic relief.

There was no significant difference in annual rate of decline in FEV_1, although the fluticasone group maintained a higher post-bronchodilator FEV_1. Fluticasone delayed the average time for a clinically significant reduction in health from 15 to 24 months. It also reduced the annual rate of exacerbations - acute respiratory deterioration requiring oral corticosteroids and/or antibiotics - by a quarter.

Inhaled corticosteroids are widely prescribed for patients with COPD, but there are few studies to support this. The ISOLDE study provides data to support the use of high dose inhaled corticosteroids in patients with moderate to severe COPD.

Survey clears regular salbutamol use

There is no evidence that regular use of inhaled salbutamol increases the exacerbation rate of asthma, according to a study in *The Lancet*.

The Regular Use of Salbutamol Trial (TRUST) measured exacerbation rates in 983 asthmatic patients being treated at least twice a week with a short-acting beta-2 agonist.

Patients were aged 18 or over, 90 per cent used inhaled corticosteroid therapy (2mg or less daily), and they all continued to use their inhaled beta-2 agonist for symptomatic relief. Patients were randomised to receive 400mcg salbutamol or matched placebo via a diskhaler, four times daily for 12 months.

There were no differences in the annual rate, timing or duration of exacerbations between the two groups. The mean morning peak expiratory flow was similar in both groups. The mean evening peak expiratory flow and the diurnal variation were greater, and the use of rescue bronchodilator was less in the group receiving regular salbutamol.

H pylori treatment benefits marginal

Community screening and treatment for *Helicobacter pylori* produces only a 5 per cent reduction in dyspepsia.

A study of 8,455 patients from 36 primary care centres, screened and treated for *H pylori* infection, found that this small reduction had no impact on quality of life.

Patients aged 40-49 were assessed by carbon-13-labelled urea breath test in the study from *The Lancet*. Infected participants were randomly assigned either active treatment of omeprazole 20mg, clarithromycin 250mg, and tinidazole 500mg, each twice daily for seven days, or placebo. Follow-ups were at six months and two years.

Dyspepsia or symptoms of gastro-oesophageal reflux were reported in 28 per cent of the treatment group and 33 per cent of the placebo group. Dyspepsia is associated with a poor quality of life in patients attending secondary care; but *H pylori* eradication in this study showed no improvement in quality of life.

Researchers said the clinical benefits of community *H pylori* eradication rested on any effect it may have on mortality from gastric cancer, with which it is linked. Because dyspepsia is an expensive problem, a cut in dyspepsia rates may be associated with a reduction in health service costs.

IN BRIEF

Isordil Tembids out of stock

Isordil Tembids is no longer available from wholesalers or the manufacturer. As no early resolution to the stock problem is in sight, Shire Pharmaceuticals suggests that patients are advised to seek an alternative preparation.

Shire Pharmaceuticals Ltd.
Tel: 01264 348562.

Larger size Deflatine launched

Roche has added a 36-tablet pack size to its Rennie Deflatine range. The new pack retails at £4.79.

Roche Consumer Health.
Tel: 01707 366000.

Additional indication for Lescol

Lescol (fluvastatin) has been granted an additional indication for the reduction of triglycerides in patients with primary hypercholesterolaemia and mixed dyslipidaemia.

Novartis Pharmaceuticals UK Ltd.
Tel: 01276 692255.

Cancer pack for NPA members

Copies of the *Living with cancer* pack have been distributed to National Pharmaceutical Association members with their May issue of the NPA Supplement. Produced in conjunction with CancerBACUP, the pack gives information on daily living, financial products, insurance, local support, as well as CancerBACUP services such as its freephone information service and website. It also contains a leaflet written by the NPA explaining services available from community pharmacists.

The National Pharmaceutical Assoc.
Tel: 01727 832161.

Fragmin's embolism role

Fragmin (dalteparin sodium) has been granted an additional licensed indication for the treatment of pulmonary embolism. The recommended dose is 200IU/kg, once daily; for those at high risk of bleeding the dose regimen is 100IU/kg, 12-hourly.

Pharmacia & Upjohn Ltd.
Tel: 01908 661101.

Ismelin: let there be light

The storage recommendations for Ismelin (guanethidine) have been amended to remove the requirement that it be protected from light.

Alliance Pharmaceuticals Ltd.
Tel: 01249 466966.

Counterpoints

Care offers more cystitis relief

Thornton & Ross is adding GSL cystitis relief powder sachets to its Care range.

Care Cystitis Relief Sachets contain the active ingredient sodium citrate dihydrate BP. When dissolved in water, the product has a pleasant lemon flavour.

Presented in distinctive blue packaging, each pack contains six sachets (rsp £3.49).

A new merchandising unit will support the launch. The unit holds six product boxes and consumer information cards about cystitis.

A launch bonus deal is available.

Thornton & Ross.
Tel: 01484 842217.

Vernaid breaks into OTC woundcare

Vernon-Carus, which specialises in hospital wound care, is breaking into OTC woundcare for pharmacy.

The new Vernaid range includes absorbent cotton dressings, crepe support bandages, highly absorbent non-stick dressings, multi-purpose bandage, self-adhesive bandage, film dressings and micro-porous tape.

Retail prices range from £1.59 for the multi purpose bandage to £3.79 for film dressings (five per box).

The range also features a travel first aid kit (rsp £1.69).

Vernon-Carus Ltd.
Tel: 01772 744493.

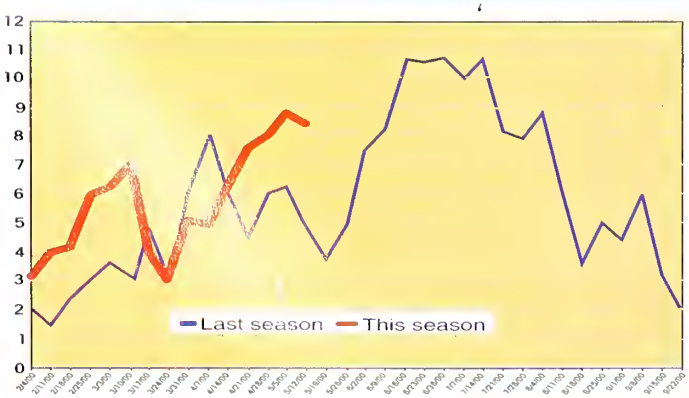
Hay Fever Monitor

Benadryl
ALLERGY RELIEF
(contains acrivastine)

HISTAMINE BLOCKER

Hay Fever ✓
Dust Allergy ✓
Pet Allergy ✓
Skin Allergies ✓

United Kingdom	Pollen level this week	Same week last season	Predominant pollen this week	Status	No. of weeks on status
BIRMINGHAM	8.9	6.3	Birch	Alert	4
BRISTOL	9.0	6.4	Birch	Alert	2
GLASGOW	6.7	4.9	Birch	Pre-alert	4
LEEDS	8.9	6.0	Birch	Alert	3
LONDON	8.4	6.8	Birch	Alert	3
MANCHESTER	8.0	6.8	Birch	Alert	3
NEWCASTLE	8.5	3.9	Birch	Alert	3
NORWICH	8.8	4.7	Birch	Alert	3
PLYMOUTH	8.2	4.0	Ash	Alert	2



Beano aims to prevent windy problems

Stafford-Miller is aiming to create a new 'preventative wind' category with its launch of Beano food supplement caplets in the UK.

The brand has been available in Canada and the US for ten years and was bought by Stafford-Miller 18 months ago.

The Beano packs feature the endorsement of the Setlers brand with the wording 'from the makers of Setlers' to provide consumers with the reassurance of the Setlers name.

Beano contains invertase – a naturally occurring enzyme to aid the digestion of carbohydrate rich foods to help avoid embarrassing wind before it starts.

Intestinal wind is commonly caused by 'healthy' foods such as beans, pasta, vegetables and pulses, as well as more obvious meals like curries, chillies and Chinese take-aways.

Two tablets should be taken just before eating the problem food. The retail price is £4.25 for 28 tablets.

The launch will be supported by a £500,000 marketing campaign.

Stafford-Miller Ltd.
Tel: 01707 331001.

Boost for Canesten Dermatological range

Bayer is planning its biggest ever focus on support for its Canesten Dermatological 'P' products this year.

New PoS material has been specifically designed to group the Canesten Dermatological products together in pharmacies.

A shelf backwall merchandiser has been on trial in an independent multiple in the Portsmouth area and it will be available nationally from the end of May.

The unit holds four of each of Canesten powder and spray with six of each Canesten 1 per cent cream and Canesten Hydrocortisone cream.

A £250,000 advertising campaign will support the Canesten Dermatological products this year.

Laser Health Care.
Tel: 01202 780558.

Nexcare plasters hit the spot

3M Health Care has extended its Nexcare first aid range with a plaster designed specifically for injection sites and small wounds.

Nexcare Comfort Strips plasters – spots (£2.49 for 36) are likely to be particularly useful to diabetes sufferers.

The plasters are made from a soft, velvety material that is comfortable to wear and gentle to remove. They also feature an airflow pattern that allows the skin to breathe.

- 3M has also launched its Coban self-adherent support bandage (rsp £2.99 per roll) as part of its Nexcare range.

The lightweight bandage comes in a 5cm width and sticks to itself without the need for safety pins.

3M Health Care.
Tel: 01509 613081.

This way for a service you can rely on.

Single point of Contact. Expanded delivery fleet. Restructured salesforce. These 3 areas are typical examples of our determination to provide independent pharmacy with the very best of service.

Of course we recognise the need to deliver the products you want, when you want them. That's why we strive for the highest levels of stock availability and why we have expanded our delivery fleet to ensure there's no delay in bringing products to your pharmacy. We've also restructured our sales force to provide you with a regular face-to-face contact who can help you with everything from special offers orders to contacts for financial advice.

We also provide a single point of contact at your local branch. They're well trained, friendly and always ready to help. Add to this our Surgical Advice Line and Community Pharmacy hotline and you can see why UniChem's service is so highly rated by our independent pharmacy customers.

UniChem
Delivering Healthcare

ERVICE + INNOVATION + EXCELLENCE + PARTNERSHIP

UniChem Ltd., UniChem House, Cox Lane, Chessington, Surrey KT9 1SN. Tel: 0181 391 2323.

Nip hay fever in the bud – nasally

Thornton & Ross is supporting its pharmacy only Care Hay fever Relief Nasal Spray with a new promotional package.

Eye-catching PoS material is now available featuring the strapline 'nip hay fever in the bud'. It includes showcards with integrated leaflet holders, free consumer information leaflets and shelf wobblers.

A series of reader offers will appear in many regional newspapers and women's magazines from this month.

Thornton & Ross Ltd.
Tel: 01484 842217.

Going for gold with Daktarin cream

J&J.MSD Consumer Pharmaceuticals is planning to launch a new Pharmacy-only anti-fungal cream that contains the active ingredient ketoconazole which was previously only available on prescription.

Daktarin Gold Cream, which contains ketoconazole (two per cent), will be available from June 1. It is a broad spectrum anti-fungal cream that is formulated to give fast relief from itching and treat athlete's foot between the toes in one week of treatment.

A clinical study shows the cream has a mycological cure rate of 93 per cent in seven days of treatment, with 91 per cent of symptoms healed or significantly improved on this timescale for athlete's foot between the toes.

The study shows there is no relapse of infection for at least as long as eight weeks after the start of the one week treatment.

The product is indicated for Dhobie itch and sweat rash as well as for athlete's foot. It should be applied twice daily to the affected skin for seven days.

For athlete's foot on the soles or side of the feet and other indications, the cream should be applied to the affected area for two to three days after symptoms have cleared.

The launch will be supported by a £1.5 million advertising campaign. As well as TV, the brand will be advertised on key sports sites on the Internet.

Retail price is £4.99 for a 15g tube.

J&J.MSD Consumer Pharmaceuticals.
Tel: 01494 450778.

Zirtek garden campaign grows to help sales bloom

UCB Pharma is stepping up its support for Zirtek by extending TV and radio advertising this summer.

A new TV commercial features the familiar Zirtek garden scene with strong product claims. Airtime on Channel 4 during May and June is being supplemented with ITV regions including Carlton, Central and West Country TV in June. GMTV is booked from now until the end of August.

A new radio commercial is being aired on local stations in London, South East and the Midlands.

● Visitors to the internet site *www.pollenforecast.worc.ac.uk* will be able to see how high the hay fever risk may be and gauge antihistamine requirements more accurately.

UCB Pharma has produced the new web site in association with The National Pollen Research Unit. It provides a two-day grass pollen rating and the outlook for subsequent days in various regions of the country.

The site can also be accessed through the Zirtek Allergy banner advertisement on the *C&D* web site on *www.dotpharmacy.co.uk*

UCB Pharma Ltd.
Tel: 01923 211811.

New look pack for Dozol

Typharm Ethical Pharmaceuticals is introducing a new look for its pharmacy only Dozol brand.

The new pack features the words 'oral solution' instead of 'teething syrup'. The pack change is designed to help pharmacies draw attention to the wide range of uses for the brand.

The product is a caramel-flavoured solution that is formulated to ease the discomfort associated with many childhood illnesses.

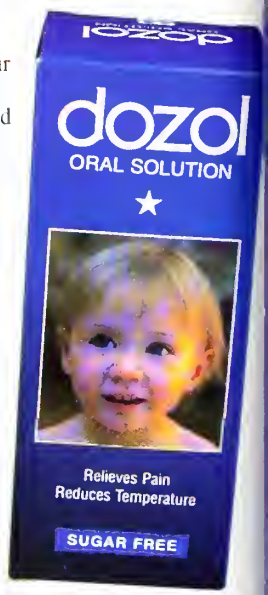
Containing paracetamol and diphenhydramine, the product is indicated for the treatment of mild to moderate pain, headache, sore throat, aches and pains. It gives symptomatic relief of influenza and feverish colds.

The dosage for three months to one year has been changed on pack to 2.5ml - 5ml (half to one teaspoon) three to four times daily.

The brand is being supported by local radio advertising and a press campaign in mother and baby magazines.

Retail price is £2.99 for 100ml.

Dendron Ltd.
Tel: 01923 229251.



Pink cross campaign targets mums

Bayer Consumer Care is supporting Germolene antiseptic cream with the brand's biggest advertising campaign.

Targeting mothers with young children, the £750,000 press campaign will run in women's magazines from May to August.

The bold advertisements focus on the brand's distinctive pink cross and the simple message that Germolene is the cream with a local anaesthetic 'to take the pain away.'

To coincide with the campaign, Bayer has also produced 5,000 specially designed PoS units which will be available to independent pharmacies via distributors Laser Health Care.

Laser Health Care.
Tel: 01202 780558.

The No.1 recommended analgesic brand[1] is still only available in pharmacy

Think Ibuprofen
Think Cuprofen

Thanks to your recommendation, the best selling success of Cuprofen in pharmacy continues.[2] Cuprofen offers the premium brand quality, performance and value for money price your customers like - and the profits you want. And as Cuprofen remains loyal to pharmacies - no grocers, no garages, no newsagents - your customers will remain loyal to you.

SSL International plc

Further information is available from SSL International plc, Tubiton House, Oldham OL1 3HS. Telephone: 0161 652 2222.
Cuprofen is a Trade Mark of Seton

Taylor Nelson Sofres Counterpoint MAT Quarter 4 1999
Cuprofen is the best selling 400mg brand - Independent Pharmacy Audit MAT Jan 2000

Cuprofen
IBUPROFEN TABLETS

New talk-line advises on hair removal

Wilkinson Sword is introducing a new initiative designed to present the company as experts in the women's shaving category.

Wilkinson is setting up a hair removal helpline designed for women, with a special emphasis on teenage girls.

The Wilkinson Sword Lady Protector + hair removal helpline (07000 474 474) will offer advice relating to all aspects of hair removal, including the best method to use for each part of the body; and a dermatologist will be available to answer more complex queries.

Every caller will be able to request a free eight page booklet giving more detailed information about hair removal.

Consumers will be encouraged to use the helpline via a PoS campaign and razor packs will carry the helpline number.

Wilkinson Sword Ltd.
Tel: 01494 533300.

Top of the Mornys relaunched

Malibu Health Products is reintroducing its range of Morny toiletries, which have been off the market for the last year.

The new-look range has been 'streamlined' and includes only the best-selling fragrances – French Fern, English Rose, Original Lavender and Sandalwood.

More attractive packaging is being introduced for the boxes of soaps (either two 150g bars or three 100g bars), which contain tissue wrapped soaps in cartons.

The talc comes in a brightly coloured tin; body lotion and bath and shower gel are in slimline bottles with flip-tops. Retail prices are £4.95 for the soaps and £3.95 for other products.

Malibu Health Products Ltd.
Tel: 020 8758 0055.

IN BRIEF

Non-GM organic cotton wool

Macdonald and Taylor is launching organic cotton wool under the Simply Gentle Organic brand. The fully certified GM-free product is being test-marketed in 100 Waitrose stores. The range includes organic cotton balls, pleats and make-up removal pads. Retail prices range from £1.25 for 100 balls, to £1.75 for 100 pads.

Macdonald and Taylor.
Tel: 0161 627 3848.

Sun-damage advice blitz

Malibu Health Products is distributing a leaflet, 'Be aware in the sun', to 4,500 doctors' surgeries around the country. The leaflet explains the risks of spending long hours in the sun. It emphasises how the sun's damaging rays can be minimalised by using good protection.

Malibu Health Products Ltd.
Tel: 020 8758 0055.

Thrush data goes on line

Pfizer Consumer Healthcare is launching a website offering consumers and health professionals information on thrush. The Thrush Advice Bureau On-Line, at *www.thrushadvice.org*, has details on the causes and symptoms of thrush, treatment options, self- help tips and myths about the condition.

Pfizer Consumer Healthcare.
Tel: 01420 84801.

Beconase Allergy is on the map

Glaxo Wellcome is supporting Beconase Allergy with a £1.5 million marketing campaign throughout the hayfever season.

A nationwide TV campaign featuring the 'Map' commercial will run until the end of June. The campaign will be backed by sponsorship of the SKY Weather pollen report, which runs four times daily until August.

The brand will also be advertised in the sports-related consumer press. In-store PoS material is available.

Glaxo Wellcome.
Tel: 0208 990 9000.

Natural way to have whiter teeth

Grafton International is launching three new natural variants of its Rembrandt Whitening Toothpaste.

The additions are Aloe Vera & Echinacea (soothing), Raspberry Leaf & Mint (invigorating) and Papaya & Ginseng (freshening).

The toothpastes are all free from artificial sweeteners, chemicals and dyes. The whitening agent – citroxin – is derived from papaya.

The retail price is £9.95 for a 128g tube.

Grafton International.
Tel: 01543 480 100.

ON TV NEXT WEEK

Beconase Allergy: All areas

Benadryl Allergy Relief: All areas

Braun Syncro: All areas

Calpol: All areas except U

Clarityn: M, LWT, CAR, C4, GMTV, TSW, Sat, C5

Gillette Mach3 razor: All areas

Oxygen: All areas except U, CTV, GMTV

Senokot: All areas except G

Zirtek: C, CAR, HTV, GMTV, C4

A Anglia, **B** Border, **C** Central, **C4** Channel 4, **C5** Channel 5, **CAR** Carlton, **CTV** Channel Islands, **G** Granada, **GMTV** Breakfast Television, **GTV** Grampian, **HTV** Wales & West, **LWT** London Weekend, **M** Meridian, **Sat** Satellite, **STV** Scotland (central), **TT** Tyne Tees, **U** Ulster, **W** Westcountry, **Y** Yorkshire

Livostin™ Direct Nasal Spray and Eye Drops Product Information. Presentations: White sterile micro-suspensions as eye drops or nasal spray containing levocabastine hydrochloride equivalent to 0.5mg/ml levocabastine. **Uses:** Selective antihistamine product indicated for the symptomatic treatment of seasonal allergic rhinitis and conjunctivitis. **Dosage and adminis-tration:** Adults and children 12 years and over. Eye drops: 1 drop per eye, twice a day, may be increased to 1 drop per eye 3 to 4 times daily. Nasal spray: 2 sprays in each nostril twice a day, may be increased to 2 sprays per nostril 3 to 4 times daily. Treatment should not be continued for more than 4 weeks in any one hayfever season. **Contra-indications:** Hypersensitivity to any of the ingredients. Patients with significant renal impairment. **Precautions:** Oral antihistamines should not be used in addition to the eye drops and the nasal spray without the advice of a doctor or pharmacist. Do not wear soft contact lenses during treatment with the eye drops. Do not exceed the stated dose. For external use only. Eye drops storage: store below 25°c, use within one month of opening, shake well before use. Nasal spray storage: store below 30°c, shake well before use. **Use in pregnancy and lactation:** Should not be used during pregnancy. May be used during lactation. **Driving and use of machinery:** Sedation rarely reported during concomitant use of the eye drops and nasal spray. Excess alcohol should be avoided. **Side Effects:** Local irritation. Eye drops: blurring of vision, eye oedema, urticaria, dyspnoea and headache. Nasal spray: headache, fatigue and somnolence. In post marketing experience, allergic reactions have been reported for the nasal spray. **Overdose:** Unlikely following topical use. In accidental oral ingestion, supportive measures should be taken. **Legal Category:** P. **Product Licence No:** PL0242/0151 (eye drops) PL0242/0152 (nasal spray). **Package quantities/price:** Eye drops: 3ml bottle £5.75. Nasal spray: 5ml bottle £5.75. **Date of preparation:** March 2000. **Full prescribing information is available from licence holder:** Janssen-Cilag Ltd, P.O.Box 79, Saunderton, High Wycombe, Buckinghamshire, HP14 4HJ. **Distributed by:** J&J. MSD Consumer Pharmaceuticals, Enterprise House, Station Road, Loudwater, High Wycombe, Bucks, HP10 9UF. *References:* 1. Palma-Carlos AG. et al. Int J Clin Pharm Res 1988; VIII (1): 25-30. 2. Stokes TC, Feinberg G. Clin Exp Allergy 1993; 23: 791-4. 3. Tomiyama S, Ohnishi M, Okuda M. Am J Rhinology 1993; 7(2): 85-88. 4. Frostad AB, Olsen AK. Clin Exp Allergy 1993; 23:406-409.

Irritating Hayfever Eyes?

You can't recommend a faster route to relief.

On days when antihistamine tablets simply aren't enough, there's no faster relief from hayfever eyes than Livostin™ Direct Eye Drops. A single drop of the topical OTC preparation works on contact and provides measurable relief from symptoms in minutes.[1,2]

Not only is Livostin™ Direct fast, but one dose lasts for up to 12 hours,[3,4] making it an excellent alternative to oral antihistamines and other topical treatments. In addition to the eye drops a nasal spray is also available to provide effective relief from nasal symptoms, and can also be used as an immediate response to symptoms.

You simply cannot recommend a faster hayfever solution than Livostin™ Direct. Works in minutes, lasts for hours.

Only available through pharmacies. Further information is available from:
Enterprise House, Station Road, Loudwater, High Wycombe, Buckinghamshire HP10 9UF. Tel: 01494 450778
www.livostindirect.co.uk

Johnson & Johnson MSD CONSUMER PHARMACEUTICALS

Senokot
The natural answer

Over the past five weeks, Senokot has introduced you to the Diet Modifiers and explained how you can help them choose the correct constipation remedy to suit their needs.

We have also taken a look at constipation and the laxative market and the reasons why Senokot is the Number 1 recommended OTC brand for sufferers of occasional constipation.

Here, in the final part of the series, we highlight the main points of discussion.

The Diet Modifiers

- One in two people in the UK suffer from constipation at some point in their lives.
- 65 per cent of these people do not treat their constipation with a laxative – they modify their diet in various ways.
- Diet modification is a good action to take but can be potentially unpredictable and slow to work.
- Many Diet Modifiers still experience symptoms like pain and bloating while they are waiting for their diet modification to work.

Diet Modifiers are still unhappy with diet modification because it is potentially so slow and unpredictable

Seeking help

Why do many Diet Modifiers feel reluctant to approach you for help?

- **Embarrassment** – they feel isolated as they do not realise how common a condition constipation is.
- **Helplessness** – they think that nothing can be done or that the alternative to diet modification is worse than the suffering they are currently experiencing.
- **Guilt** – they think that their constipation is something they have brought upon themselves and that people will think 'badly' of them.
- **Fear** – they think that all laxatives are unnatural, chemical, purgative and have an unpredictable action.

Through a highly targeted promotional campaign, Senokot aims to overcome the Diet Modifiers' embarrassment and their fears about laxatives.

The new Senokot TV advertisement entitled 'Dreams' hit the screens nationwide from May 15th and directly addresses the fears that Diet Modifiers have about laxatives, as well as informing them that a natural, effective and predictable answer is available at their local pharmacy.

Diet Modifiers want a constipation remedy that:

- contains natural ingredients
- is predictable and quicker than diet, but not immediate
- is gentle
- is easy to take

The natural answer

Senokot, which contains standardised natural senna, is the most frequently self-selected constipation remedy and the Number 1 recommended OTC brand for sufferers of occasional constipation. Senokot provides effective and predictable relief from occasional constipation, usually in 8 to 12 hours.

The benefits of Senokot

- contains natural senna
- gentle effect on the bowel
- easy to take
- predictable speed of action
- overnight relief

Senokot tablets come in packs of 6, 20, 60 and 100 retailing at £1.29, £1.89, £4.34 and £5.19 respectively. Senokot syrup comes in 100ml bottles retailing at £3.05. Senokot granules 100g retail at £4.49.

So, you can be confident that in recommending Senokot as the treatment of choice for Diet Modifiers you will be both meeting their needs and growing your category sales.

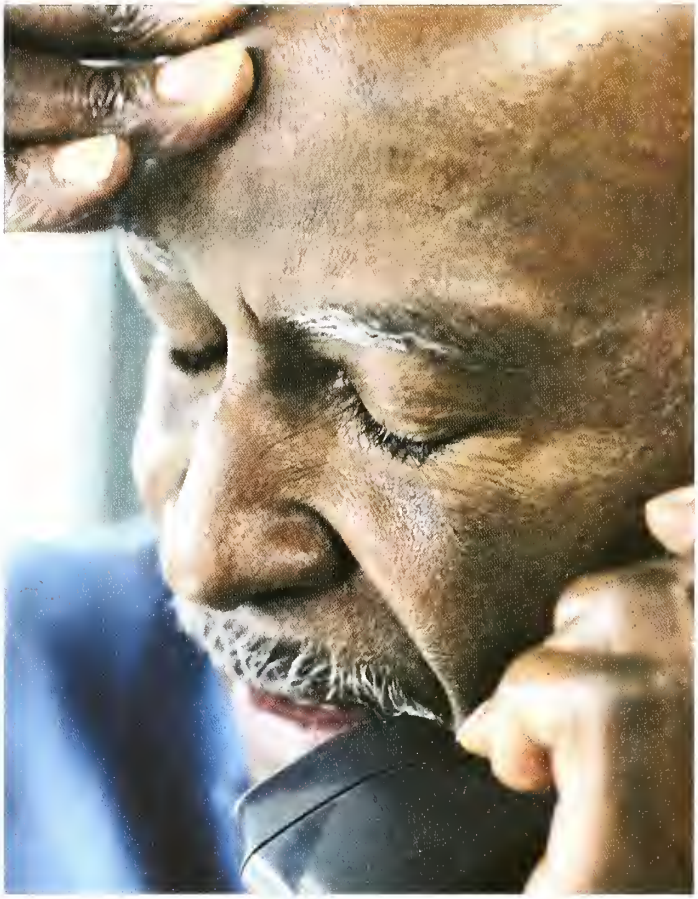
Senokot®

Contains natural Senna

Senokot Essential Information ***Active Ingredients:*** Each Tablet contains standardised senna equivalent to 7.5mg total sennosides. Each 5ml spoonful of Syrup contains standardised senna extract equivalent to 7.5mg total sennosides and 3.3g of sugar. Each 5ml (2.73g) spoonful of chocolate Granules contains standardised senna equivalent to 15mg total sennosides and 1.64g of sugar. ***Indications:*** Relief of occasional or non-persistent constipation. ***Dosage Instructions:*** Adults and children over 12: Two Tablets in 24 hours, or two 5ml spoonfuls of Syrup, or a level 5ml spoonful of Granules, taken at night. Children 6-12: One 5ml spoonful of Syrup taken in the morning. Tablets and Granules to be taken only on a doctor's advice. Children under 6: Syrup to be taken only on a doctor's advice. Tablets and Granules not recommended. ***Contraindications:*** In common with other laxatives Senokot should not be given when undiagnosed acute or persistent abdominal pain is present. ***Precautions and Warnings:*** If there is no bowel movement after three days consult a doctor. If laxatives are needed every day or abdominal pain persists consult a doctor. Do not take Senokot Syrup or Granules if you are a diabetic. ***Side Effects:*** Temporary mild griping may occur during change in dosage. ***Retail Sale Price:*** Tablets: 6 Tablets – £1.29, 20 Tablets – £1.89, 60 Tablets – £4.34, 100 Tablets – £5.19. Syrup: 100 ml – £3.05. Granules: 100g – £4.49. ***Marketing Authorisations:*** Senokot Tablets – 0063/5000R, Senokot Syrup – 0063/5003R and Senokot Granules – 0063/5002R. ***Supply Classification:*** Through registered pharmacies except 6's tablet pack (GSL). ***Holder of Marketing Authorisations:*** Reckitt & Colman Products Limited, Dansom Lane, Hull, HU8 7DS. ***Date of Preparation:*** April 2000.

Drugs to deal with migraine

In this second article on migraine, Derek Balon explains the treatment options now available



Increased knowledge of the possible pathogenesis of migraine with identification of various types of 5-HT receptors has resulted in new drugs, the triptans, to treat acute migraine attacks. But because the success rate far these newer drugs still leaves something to be desired, there remains a place for older drugs in treatment of migraineurs.

The drugs used for acute migraine attacks include analgesics, NSAIDs, triptans and ergot alkalaids. The first two are non-specific while the latter two are targeted, their actions being attributed ta their 5-HT agonist properties.

There are considered to be at least three potential levels at which selecfive 5-HT agonists may influence a migraine attack (see Fig 2 overleaf):

- vasoconstriction of some intra/extra cranial vessels
- pre-synaptic inhibition of release of inflammatory neuropeptides from sensory nerve endings in the meninges
- inhibition of central transmitter release in the brain.

It is possible that all three actions occur with some of the drugs, but tine detail ot the specific mode af actian of 5-HT agonists is still not completely resolved.

There are many different types of 5-HT receptor sites in the bady and brain. Each type has a different profile of physiological actian and the different triptans probably have different affinities for these different receptors. This wauld account, in part, for fheir different action profiles. Another tactor is their individual pharmacodynamic and pharmacakinetic profiles.

Analgesics and NSAIDs exert their action by reducing the effects of any pain producing, inflammatory neuropeptides that are released. Other drugs used to treat symptoms ather than the headache alsa act by their

Continued on PII →

THE COLLEGE OF PHARMACY PRACTICE

THIS COURSE (MODULE 1164), IN ASSOCIATION WITH MULTIPLE CHOICE QUESTIONS BEING PUBLISHED IN *C&D* JUNE 10, PROVIDES ONE HOUR'S CONTINUING EDUCATION

OBJECTIVES

- To understand the significance of 5-HT receptors in treatment of migraine
- To be aware of the different classes of drug available to treat migraine
- To understand the benefits and risks of using triptans and alkaloids to treat migraine
- To recognise the role of analgesics and ancillary drugs in relieving symptoms of migraine
- To be able to advise patients about the type of migraine treatment they are receiving

Table 1: Migraine relief for different triptans after oral administration

	% relief from placebo 1 hour	2 hours	Number needed to harm*	% oral bioavail	$T_{1/2}$(H)
Sumatriptan (50/100mg by oral admin)	22/26	33/33	14.3/5.9	14	2
Zolmitriptan	18	34	5.9	40	3
Naratriptan	8	21	1181	63-74	6
Rizatriptan	21	36			

* Number needed to harm. The higher the number, the fewer the adverse effects

Continued from PI

standard mechanism: for example metoclopramide influences nausea and vomiting and promotes intestinal motility.

The triptans

The triptans are a relatively new group of medically active compounds (3:5 substituted indoles) that are used to treat migraine headache.

Measurement of the efficacy of anti-migraine drugs is difficult. There are major problems with the placebo effect and when to measure results.

The 'when' is related to the fact that migraine headaches often remit, only to re-occur a few hours later. Measurements made too soon after headache relief do not present a true clinical picture. This problem is compounded by the fact that the first triptan (sumatriptan) has a half-life of about two hours. Some of the results of trials on the triptans are shown in Table 1 (see previous page).

It is clear that the present triptans are effective in some patients but the success rate is not outstanding. Side effects, which are very common, include a tingling sensation, heaviness, and heat.

Chest and throat pain may occur; the mechanism for this is not clear but may be related to coronary vasoconstriction. However, cessation of the drug is required if this occurs. The incidence of chest pain in patients treated with oral sumatriptan has been reported as high as 15-24 per cent (higher for parenteral administration).

The newer triptans are better absorbed from the gut and this is one reason for their development. However, their success rate is still not optimal.

Sumatriptan was introduced into practice in the early 1990s. It is available in tablet, injection, and a nasal spray formulations (and in some countries as a suppository).

The reason for these various presentations is related to its absorption. The first form available was the injection, which provided about 96 per cent bioavailability of the drug. But this delivery route is not ideal for the majority of migraineurs.

Oral administration results in a bioavailability level of about 14 per cent. Therapeutic blood levels are reached in 30 90 minutes, with a half-life of about two hours. Nasal administration increases bioavailability slightly to about 16 per cent.

A single tablet (50 or 100mg) or injection is used to treat a migraine attack. If this is not successful, a second dose is not recommended since it is unlikely to be effective. If effective, a second dose may be taken after one to two hours but the total daily dosage must not exceed 300mg.

The nasal spray offers little advantage over other formulations except that it has faster onset of action. A specific side effect is that it creates a bad taste in the mouth.

Zolmitriptan is available as a 2.5mg tablet. Its bioavailability after oral administration is about 41 per cent. Unlike sumatriptan it crosses the blood-brain barrier. This property is believed to confer the ability to reduce stimulation of the direct pathways within the brain that add to the sensation of a migraine headache (see Fig 2). However, when administered orally there is little clinical evidence for any marked superiority of this drug over sumatriptan.

Naratriptan is also available as a 2.5mg tablet. It has better bioavailability than sumatriptan and increased lipophilicity, which could improve headache reduction.

However, the published comparative data, clinical trial, and 'in practice' studies for the newer triptans is insufficiently clear to indicate it is the drug of choice. It does, though, appear to induce side effects less frequently than the earlier triptans.

Rizotriptan, the latest triptan to reach the market, comes in two forms; two strengths of tablets (5mg and 10mg) and wafers (10mg). It is claimed to have a more rapid onset than sumatriptan: some patients experience headache relief within 30 minutes.

The wafer form is designed so that the drug is dissolved in saliva and then swallowed. Pharmacokinetic studies confirm that this form has the same absorption profile as the oral tablet, presumably since it enters the body from the lower part of the gastro-intestinal tract and not the buccal cavity, regardless of the administration route.

In spite of the different pharmacodynamic and pharmacokinetic properties, there is no clear-cut drug of choice at present.

This is not the end of the triptan story; other compounds (eletriptan, almotriptan, frovatriptan) are at various stages of development, and perhaps some will exhibit profound advantages over those currently available.

Ergot alkaloids

The ergot alkaloids have been used to treat migraine attacks for over 50 years. The major active constituent of value is ergotamine and its derivative, dihydroergotamine. However, until the recent development of a dihydroergotamine nasal spray,

Continued on PIV →

Figure 1: Possible pathways of migraine

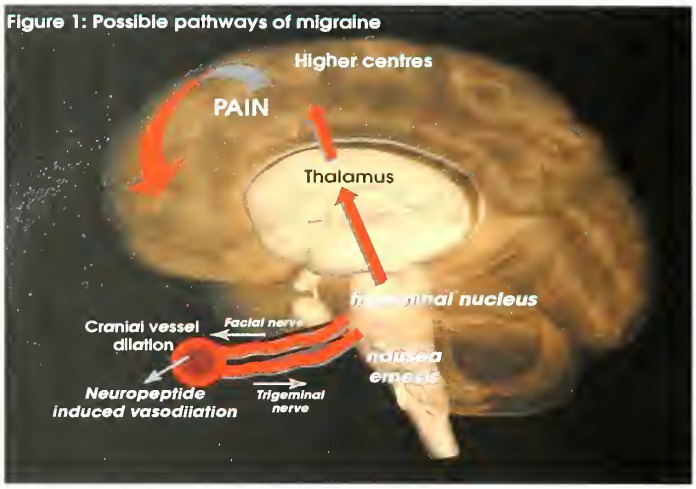
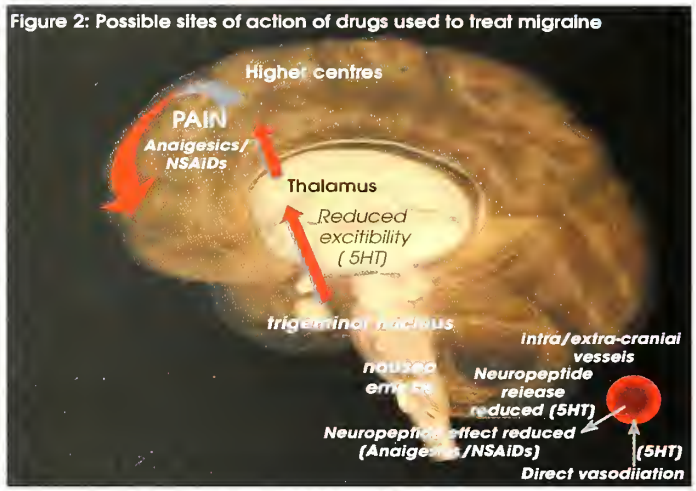


Figure 2: Possible sites of action of drugs used to treat migraine



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Continued from PII

there was little evidence for the rational prescribing of ergot products.

These compounds have poor orol and rectal bioavailability with erratic pharmacokinetic and clinical response profiles.

It was thought that the nasal spray would overcome some of the absorption and first pass metabolism effects of oral administration, but the results of clinical trials were disappointing.

The mechanism of action of the ergot derivatives is probably related to their 5-HT agonist effects. They have been shown to inhibit the release of CGRP in humans, probably through a mechanism related to their 5-HT effect.

These compounds are potent vasoconstrictors and also have a secondary effect of stimulating dopamine D2 receptors in the central nervous system and the intestine, leading to nausea and vomiting. These vasoconstrictor and gastric effects limit their use in practice but they have value for some patients, especially if they suffer from prolonged acute attacks.

Table 2: Some drugs used to prevent/treat migraine attacks

Drug	Adult dose	Choice	Contra-indication*/cautions
Headache			
Aspirin	300-900mg	First line	Gastric problems, aspirin allergy/sensitivity, not for use in children under 12
Paracetamol	500-1000mg	First line	Renal/hepatic disease
NSAIDs	various	Simple treatment	Asthma, gastric problems
(Tolfenamic acid)	100-200mg	Second line	As NSAIDs
Nausea			
Metoclopramide	10mg	First line	Epilepsy, renal/hepatic disease, not for use in children under 12
Domperidone	10-20mg	First line	Not for use in children under 12
Direct CNS action			
Triptans	various	Second line	Not for use in patients under 12 or over 65, hypertensives, vascular disease
Ergotamine	1-2mg oral	Third line	Vascular/ischaemic disease
Prophylaxis			
Beta-blockers	various		Asthma
Amitriptyline	10-25mg tds		As for all tricyclics
Clonidine	50-75mcg tds		Tendency to depression
Pizotifen	1.5-3mg daily (tds or at night)		Weight gain

** Except for paracetamol all are contra-indicated for pregnancy and breast-feeding*

The role of analgesics

As the prime symptom of migraine is the headache, analgesics are of value for the condition. Aspirin and paracetomol are regarded as first-line treatments, although the NSAIDs have been shown to be superior in relieving the headache of migraine in some studies.

'Stronger' analgesics such as codeine, dihydrocodeine and dextropropoxyphene have been used, either on their own or in combination. The addition of opioids to simple analgesics often leads to more rebound headaches, and should not be encouraged.

Tolfenamic acid is the only NSAID licensed for treatment of acute migraine. The rationale behind the use of NSAIDs is that the pathogenesis of migraine indicates that perivascular inflammation leads to the release of neuropeptides and other substances including the kinins and leukotrienes.

Tolfenamic acid has been shown to inhibit the synthesis of the prostaglandins and leukotrienes. It is now available as an orally administered and rapidly absorbed preparation, which appears to offer some advantages over traditional formulations.

It has been shown to be as effective as sumatriptan in reducing headache in migraineurs, but is considerably cheaper.

Ancillary drugs

The symptoms of migraine include nausea with or without vomiting. This appears to be a primary CNS effect of the condition. Gut motility is also reduced, with concomitant reduction of gastric absorption. These effects can be reduced with the motility stimulants, metoclopromide and domperidone, both of which are also anti-nauseants.

They can be used on their own to combat nausea and vomiting, but have a significant role to play in improving absorption of the analgesics used in treating an acute attack of migraine.

Two studies suggest that the combination of aspirin (in one case, the lysine salt) and metoclopramide is as effective as oral sumatriptan in relieving migraine headaches. Various combinations of metoclopramide and aspirin or paracetamol are available commercially in the UK.

Buclizine is a piperazine antihistamine that has central sedative and antinausea activity. It is available in the UK for treating an acute attack of migraine as an OTC preparation, in which it is combined with paracetamol and codeine.

Practice guide

Diagnosis of migraine depends upon the symptom complex and the absence of other conditions.

Treatment has two facets: prophylaxis and drug intervention. Neither praphylaxis nor treatment are totally effective and various management strategies are proposed.

For the pharmacist, the only drug interventions available are the analgesics, possibly combined with a supply of domperidone (outside the OTC licence), or the commercially available analgesic/buclizine combination.

Avoidance advice may be of value but there is little evidence to support this. In spite of reservations about avoidance, viewing television or computer screens, or having fluorescent lighting may trigger migraine and thus should be taken into consideration.

The first part of this module on migraine appeared in **Pharmacy Update** on May 6.

C&D *is accredited by the College of Pharmacy Practice as a provider of distance learning until March 2001.*

The on-set of migraine can make you want to pull your hair out

the only licensed potassium sparing diuretic in an oral liquid form

Did you know that there is a potassium sparing diuretic in oral liquid form, which provides an alternative to tablets for the elderly and patients with swallowing difficulties. Amilamont is sugar free, and comes in a ready to use 5mg/5ml strength for easy dose administration and can be used with other diuretics such as Frusemide.

Another easy to swallow option from

ROSEMONT

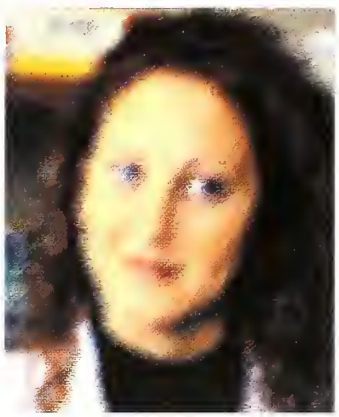
THE SPECIALISTS IN ORAL LIQUID MEDICINES

'Amilamont' Amiloride Hydrochloride Oral Solution 5mg/5ml

bbreviated Prescribing Information. Presentation: Amilamont is an oral solution containing Amiloride Hydrochloride BP equivalent to 5mg anhydrous Amiloride Hydrochloride in each 5ml. **Therapeutic dications:** It is a potassium sparing diuretic, principally used as concurrent therapy with thiazides or more potent diuretics to conserve potassium during periods of vigorous diuresis and during long term maintenance therapy. In patic cirrhosis with ascites, Amilamont usually provides adequate diuresis, with diminished potassium loss and less risk of metabolic alkalosis, when used alone. It may be used with more potent diuretics when greater diuresis is required ile maintaining a more balanced serum electrolyte pattern. **Posology and Method of Administration:** Adults: Amilamont alone. The usual initial dosage is 10mg (as a single dose or 5mg twice a day). The total daily dose ould not exceed 20mg a day. After diuresis has been achieved, the dosage may be reduced by 5mg increments to the least amount required. Amilamont with other diuretic therapy: When Amilamont is used with a diuretic, which is given an intermittent basis, it should be given at the same time as the diuretic. Hypertension 5 or 10mg a day, together with the usual antihypertensive dosage of thiazide concurrently employed. It is not usually necessary to exceed 10mg of ilamont a day, in any event not more than 20mg of Amiloride Hydrochloride should be given. Congestive heart failure Initially 5 - 10mg a day, together with the usual dosage of the diuretic concurrently employed. If diuresis is not hieved with minimal dosage of both agents the dosage of both agents may be increased gradually, but that of Amilamont should not exceed 20mg a day. Once diuresis has been achieved, reduction in dosage of both agents may be attempted maintenance therapy. The dosage of both drugs is determined by the diuresis and the level of plasma potassium. Hepatic Cirrhosis with ascites Treatment should be started with a small dose of Amiloride Hydrochloride i.e. 5mg plus a dosage of the other diuretic agent. If necessary, dosage of both agents may be increased gradually. The dosage of Amiloride Hydrochloride should not exceed 20mg a day. Maintenance doses may be lower than those required to initiate uresis, reduction in the daily dosage should therefore be attempted when the patients weight is stabilised. Children Contra-indicated. Elderly The dosage should be carefully adjusted according to renal function, blood electrolytes and uretic response. **Contra-indications:** Hyperkalaemia (plasma potassium over 5mmol/l) other potassium-conserving agents or potassium supplements (see Precautions); anuria; acute renal failure. severe progressive renal disease, abetic nephropathy (see Precautions); prior sensitivity to this product. Safety for use in children is not established. **Precautions & Interactions:** Diabetes Mellitus: In known or suspected diabetic patients, the status of renal nction should be determined before initiating therapy. Amilamont should be discontinued for at least three days before a glucose tolerance test. Metabolic or Respiratory Acidosis: Potassium conserving therapy should be initiated only h caution in severely ill patients in whom metabolic or respiratory acidosis may occur. Hyperkalaemia: This has been observed in patients receiving amiloride alone or with other diuretics. These patients should be observed carefully for nical, laboratory or ECG evidence of hyperkalaemia. Some deaths have been reported in this group of patients. Hyperkalaemia has been noted particularly in the elderly and in hospital patients with hepatic cirrhosis or cardiac oedema o have known renal involvement, who were seriously ill, or were undergoing vigorous diuretic therapy. Neither potassium-conserving agents nor a diet rich in potassium should be used with Amilamont except in severe and/or refractory es of hypokalaemia. If the combination is used, plasma potassium levels must be continuously monitored. Impaired renal Function: Patients with increases in blood urea over 10mmol/l, serum creatinine over 130(mmol/l, or with diabetes llitus, should not receive Amilamont without careful, frequent monitoring of serum electrolytes and blood urea levels. In renal impairment, use of a potassium conserving agent may result in rapid development of hyperkalaemia. Treatment Hyperkalemia: If hyperkalaemia occurs, Amilamont should be discontinued immediately and, if necessary, active measures taken to reduce the plasma potassium level. Electrolyte Imbalance and Reversible Blood Urea Increases. ponatraemia and hypochloraemia may occur when Amilamont is used with other diuretics. Reversible increases in blood urea levels have been reported in accompanying vigorous diuresis, especially when diuretics were used in seriously patients, such as those with hepatic cirrhosis with ascites and metabolic alkalosis, or those with resistant oedema. Careful monitoring of serum electrolytes and blood urea levels should therefore be carried out when Amilamont is given h other diuretics to such patients. Cirrhotic patients: Oral diuretic therapy is more frequently accompanied by side effects in patients with hepatic cirrhosis with or without ascites. In patients with pre existing severe liver disease, hepatic ephalopathy manifested by tremors, confusion and coma, and increased jaundice have been reported in associated with diuretics, including Amiloride.Lithium should not be given with diuretics. When combined with thiazide diuretics, iloride can act synergistically with chlorthiazide to increase the risk of Hyponatraemia. When Amiloride is administered concomitantly with an angiotensin-converting enzyme inhibitor, the risk of hyperkalaemia may be increased. **egnancy and Lactation:** Because clinical experience is limited, Amiloride is not recommended for use during pregnancy. It is not known whether Amiloride is excreted in human milk. **Effects on Ability to Drive and se Machines:** None known. **Undesirable Effects:** Amiloride is normally well tolerated, although minor side effects are reported relatively frequently Except for hyperkalaemia, significant side effects are infrequent. Nausea, orexia, abdominal pain, flatulence and mild skin rash are probably due to Amiloride; but other side effects are generally associated with diuresis or with the underlying condition being treated. **Overdose:** No data are available; and s not known whether the drug is dialysable. The most likely signs and symptoms are dehydration and electrolyte imbalance which should be treated by established methods. Therapy should be discontinued and the patient observed sely. No specific antidote is available. If ingestion is recent, emesis should be induced or gastric lavage performed.Treatment is symptomatic and supportive. If hyperkalaemia occurs, active measures should be taken to reduce plasma els. The plasma half life of amiloride is about six hours. **Shelf Life and storage**: 24 months at or below 25 °C. **Legal Category** POM. **Pack Size and NHS price:** 150ml, £39.73. **Marketing Authorisation Holder d PL Number**: Rosemont Pharmaceuticals Ltd, Rosemont House, Yorkdale Industrial Park, Braithwaite Street, Leeds, LS11 9XE. PL 00427/0091.Date of preparation: March 2000

All about gout...

A prescription for probenecid and loratadine led a pharmacist to believe her patient was suffering from gout and had previously reacted adversely to allopurinol. Primary care pharmacist Mary Allen looks at gout and its treatment



Janice is a pharmacist who has recently returned to community practice, and works three mornings a week at Jill Brown's busy pharmacy. One morning she asked Jill about a particular script she was dealing with – one of the items was not a stock line, and Janice was unsure of its use. The patient, Mr B, was a 78-year-old male and, although his address was local, the pharmacy had not dispensed for him before.

The prescription

Loratadine 10mg *one daily*
Probenecid 500mg *one bd pc*
(half a tablet bd for the first week)

In the absence of any patient history, Jill told Janice that she felt that the patient had gout, and that the prescription suggested an adverse reaction to an earlier script for allopurinol, resulting in a change of medication to probenecid. Was she right?

The condition

Gout is a painful condition affecting around 0.25 per cent of the UK population. One third of patients have an associated family history. Most gout sufferers are men, and the onset of the disease is usually in middle age.

Hippocrates noted that gout does not affect men before puberty or women until after menopause. Around half of sufferers are regular drinkers of alcohol.

Gout is an acute inflammatory arthritis associated with deposits of uric acid salts in the joints. Increased blood levels of uric acid (hyperuricaemia) occur as a result of increased production or reduced excretion of uric acid.

Hyperuricaemia may be asymptomatic and in the majority of cases does not result in gout. The risk, though, increases with increased uric acid levels.

Uric acid is formed as the final breakdown product of nucleoprotein and purines, through the action of the enzyme xanthine oxidase. It is excreted mainly via the kidneys (>75 per cent) and to a lesser extent via the intestines. Renal excretion of uric acid may be affected by many factors.

Primary gout (more than 90 per cent of cases) is thought to be due to inborn errors of metabolism resulting in over-production of uric acid, or possibly to a genetic tendency to under-excretion. Secondary gout may occur as a result of the side effects of drugs, or because of a co-existing disease.

In acute gout, the body's inflammatory processes are stimulated by the deposition of uric acid crystals in a joint. Why crystal formation may be triggered at any particular time is unclear.

Trauma, infections, cold, myocardial infarction, dietary and alcoholic excess, stress and a change in local pH have all been linked with acute attacks of gout. Drugs known to affect uric acid levels, such as diuretics, may also lead to attacks.

Risk factors often occur together so the causes of gout in an individual patient are usually multi-factorial.

Symptoms and diagnosis

Typically, an acute attack of gout occurs in the early hours of the morning and affects the big toe, causing excruciating pain. In around 25 per cent of cases, joints other than the toe may be affected.

The affected toe (or joint) is hot, red, swollen and tender. Weight bearing is almost impossible. Diagnosis can be confirmed by the presence of long, needle-shaped crystals in the synovial fluid.

Untreated gout will resolve within a few weeks, though due to the excruciating pain, it is rarely left untreated. In some patients, attacks of gout may never recur, while others have recurrent attacks that increase in frequency in the absence of prophylactic treatment.

Treating acute attacks

Acute attacks are treated with non-steroidal anti-inflammatory drugs (NSAIDs), usually indomethacin 50mg three or four times daily, reducing to 25mg after a couple of days. Complete relief of symptoms may take five days. Other NSAIDs such as diclofenac or naproxen may be used instead.

Azapropazone 600mg twice daily is an alternative, and is promoted for gout because it also increases the excretion of uric acid. Aspirin should not be used to treat gout as it decreases uric acid excretion, thus increasing blood levels. Over-the-counter dosages of ibuprofen are insufficient to produce a satisfactory anti-inflammatory response.

Colchicine provides an alternative for those unable to tolerate NSAIDs such as:

- patients with a history of gastro-intestinal ulcers or bleeding
- patients with congestive heart failure
- patients on anticoagulant therapy.

Colchicine acts by inhibiting the movement of leucocytes to the site of inflammation. Treatment should be initiated as soon as possible with a starting dose of 1mg, followed by 500mcg every two to three hours until relief is obtained or until gastro-intestinal side-effects – diarrhoea, nausea, abdominal cramps and vomiting – arise. (Trying to walk to the bathroom with a very painful toe must add insult to injury!)

In any case, a total dose of 6mg should not be exceeded, and because the drug has a long half-life, it should not then be used again for at least three days.

Colchicine should be used with caution in patients with cardiac, hepatic or renal impairment, and in those with gastro-intestinal disease. Prolonged use can cause blood disorders.

Opioid analgesics, such as morphine given by intramuscular injection, may be used to provide relief in the early stages of acute gout, until the anti-inflammatory effects of prescribed NSAIDs take effect.

Corticosteroids are sometimes used via intra-articular injection where appropriate, but only after a definite diagnosis of gout, to avoid exacerbating undiagnosed infective arthritis.

Long-term therapy

Occasional attacks of gout are generally treated acutely. Where there is frequent recurrence, prophylactic treatment is usually initiated. It should, if possible, be continued indefinitely.

Long-term therapy is intended to reduce uric acid levels and thus reduce the risk of further attacks. Drugs that reduce uric acid levels work either by decreasing the formation of uric acid, or by increasing its excretion.

Allopurinol acts by inhibiting xanthine-oxidase, thus decreasing the formation of uric acid, while uricosuric agents work by increasing the renal excretion of uric acid.

Prophylactic treatment should not be initiated during an acute attack, and is usually best left until at least four weeks after an attack. Because initiation may, in fact, precipitate an attack of gout, colchicine (0.5mg twice daily) or an NSAID should be given concurrently to provide cover and continued for at least a month after blood levels return to normal.

If an acute attack occurs during therapy, the prophylactic drug should be continued at the same dosage and the attack treated in its own right.

Excess alcohol has been linked with acute attacks of gout, affecting uric acid levels

Factors affecting decreased excretion of uric acid:

- Increasing age
- Male gender
- Hypertension
- Chronic renal disease
- Increased lactic acid production from alcohol, exercise or starvation (lactic acid competes with active secretion of uric acid in the proximal tubule)
- Drugs such as diuretics (especially thiazides) and aspirin
- Hypothyroidism and primary hyperparathyroidism
- Glucose-6-phosphate deficiency

Factors affecting increased production of uric acid:

- Obesity (increased turnover of cells)
- Social class (more common in higher social classes)
- Certain diseases (conditions increasing cell turnover such as psoriasis and myelo/lymphoproliferative disorders eg leukaemia)
- Drugs such as cytotoxic agents which cause the death of large numbers of cells, thus increasing the breakdown products of nucleoproteins
- Alcohol – some beers and wines have a high purine content. Also, alcohol may increase the metabolism of purines
- Some metabolic disorders including glucose-6-phosphate deficiency (sufferers may have both increased production and decreased excretion of uric acid)

Allopurinol is widely used for long-term control of gout. Its active metabolite, oxypurinol, has a long half life, allowing once daily dosage except in higher doses, and acts by irreversibly blocking xanthine-oxidase, inhibiting the conversion of hypoxanthine and xanthine to uric acid, resulting in a 50 per cent reduction in the formation of uric acid. The xanthines are highly soluble and are excreted in the urine.

Treatment should commence with 100mg daily to reduce the risk of acute attacks and increased to a usual maintenance dose of 100mg to 600mg daily depending on severity of the condition and on renal status, although higher doses are sometimes used. Patients should maintain an adequate fluid intake of around two litres daily.

The drug is generally well tolerated but may cause rashes, requiring withdrawal of therapy. Where rashes are mild, the drug may be re-introduced with caution, but must be discontinued immediately if the rash recurs, as some patients may suffer hypersensitivity reactions.

Other side effects of allopurinol include gastro-intestinal disorders. Occasionally the drug may affect the liver or cause blood disorders.

Uricosuric agents such as probenecid or sulfinpyrazone may be used instead of allopurinol, and sometimes in addition to it. Probenecid is the more widely used of the two, in doses of 500mg to 1,500mg daily.

Crystallisation of urates in the urine may occur and it is important that patients should drink at least two litres of fluid daily, especially in the first few weeks of treatment. The drugs should not be used in patients with severe renal impairment.

Side-effects of probenecid are mostly associated with the gastro-intestinal system – nausea, heartburn and constipation. Sulfinpyrazone may also cause gastro-intestinal side effects, and very occasionally may cause bone-marrow suppression, so regular blood counts are recommended.

What about Mr B?

Jill's assumption had been based on the prescription for a seven-day course of loratadine together with a new course of probenecid (the increasing dosage suggesting it was newly prescribed). She assumed that Mr B had previously been prescribed allopurinol that had subsequently caused a rash, for which the loratadine had been prescribed.

Janice ensured that an order was placed for some probenecid for that afternoon. Ten minutes later, a neighbour of Mr B's came in to see if his prescription was ready. Jill explained that it would be available later in the day.

Just before she left, the neighbour removed a packet of tablets from her handbag, and asked Jill to dispose of them. She said that they had not suited Mr B at all, and had brought him out in a horrible rash. They were allopurinol 300mg tablets.

Measures to reduce the risk of attacks of gout

- Withdrawal of any drugs, such as thiazide diuretics, known to be associated with gout
- Weight reduction
- Reduction of alcohol intake
- Maintenance of a good fluid intake
- Avoidance of food and drinks known to have a high purine content, such as game or lager

Ethically speaking

The Royal Pharmaceutical Society approved a new professional Code of Ethics at its annual meeting last week. Ruth Rodgers, former head of ethics at the Royal Pharmaceutical Society, explains what has changed

The Royal Pharmaceutical Society's new Code of Ethics is, in fact, a vastly reduced version of the proposals sent out in a consultation document to pharmacists last September. So why has the Society chosen to review the Code of Ethics now, and how will the new version work with elements of the existing code that will be retained?

To help answer this question, it is necessary to understand the rationale for codes of practice and what they might include, the history of the pharmacists' Code of Ethics, and the four basic ethical principles.

Back to basics

Why is the Royal Pharmaceutical Society bringing out a new Code of Ethics now?

The decision to do so was taken by the Society's Council early in 1998. The Code then in place was adopted in May 1992, and had taken the working party charged with its development four years to produce. Almost as soon as it had been adopted, amendments became necessary to reflect changes both in practice and legislation.

Over the years, the Code had been altered and added to considerably. Several new Obligations, some with supporting guidance notes, had been added to the body of the Code, and additional standards added to the appendix. These have also been supplemented with a large number of Council statements.

In an attempt to rationalise this burgeoning document, many of these statements were redistributed to try to improve the layout and content. This resulted in re-writes and additions to the Standards of Professional Practice set out in the Code's appendix. The original format of the 1992 review, with Principles, Obligations and Guidance, along with the appendix, was able to accommodate many of these additions. But by 1998 it was starting to become disjointed and Council decided that it was time to go back to the drawing board.

What is ethics?

Before discussing the new document it is pertinent to consider the nature of ethics. Commonly described as a systematic study of 'what we ought to do', ethics is a branch of philosophy that emerged long after human societies had developed some kind of basic morality.

Ethics lies over and above the requirements of law although, to be fair, most law originated from moral concepts. However, unlike law, ethics is not written in stone. Its ability to reflect current socially accepted views gives ethics a flexibility in application that the processes of law do not allow.

Where societies operate within a strong ethical framework there is less need for stringent application of legislation. The converse is also

Continued on PX →

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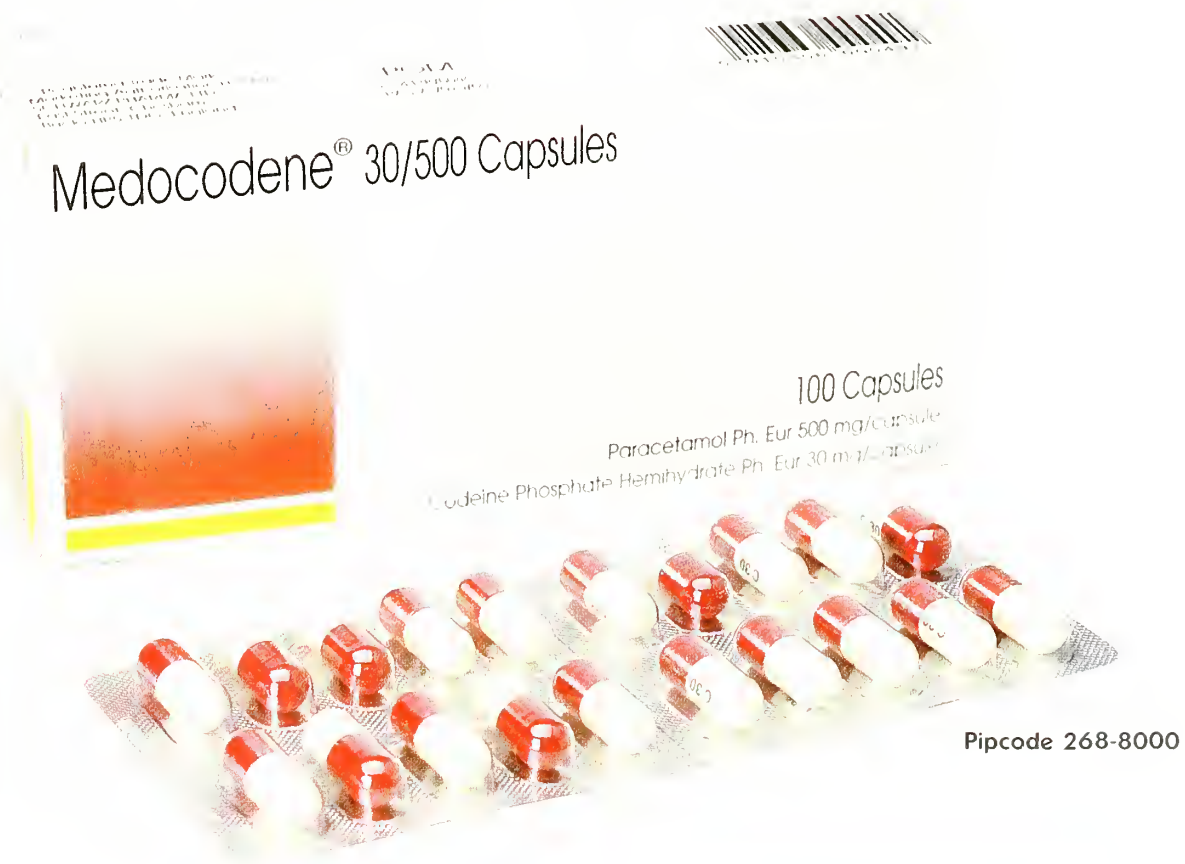

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Code 1542

Continued from PX

- Part two replaces the old Principles 4 and 5 along with Standard 7, and deals with standards of performance. In particular this covers standards of professional competence and confidentiality matters.
- The final, third part of the Code comprises the remainder of the old Code with its appendix and incorporating the new Standard 19, which concerns internet pharmacy services

The details ...

Part one: Pharmacists' ethics

This first section in Part one sets the scene with an introduction to ethics for pharmacists, and seeks to tackle the issue of professional decision making. It sets out some basic ethical concepts and relates these to the practical application of ethics within pharmacy.

Acknowledging that ethics is a balance between competing rights and responsibilities, some of the ideals to which pharmacists should aspire are considered. Also highlighted is the problem that pharmacists face when dealing with dilemmas in practice. This introduction urges the making of professional judgements that reflect the fundamental accountabilities of the profession.

Decisions should be justifiable if the pharmacist is called upon to do so. Advice is given on the need to identify and evaluate the risks and benefits associated with possible courses of action. And it recognises that every situation must be judged on its merits. This means that different pharmacists may each be able to justify reaching differing decisions.

Professional misconduct is also covered in this section. It is clearly stated that neither the Council nor the Statutory Committee regard themselves as limited to acting only on the matters included in the Code.

The second section deals in more detail with the expected relationships and general professional standards to which a pharmacist is expected to adhere. These relate back to the fundamental principles of ethics referred to earlier in this article, namely beneficence, non-maleficence, justice and autonomy.

This section does not specify how pharmacists should do their job, or give detailed instruction on all aspects of practice. If this were the case, it could be argued that pharmacy is no longer a profession since its tasks would be reduced to technical ones, with no place for judgements to be made.

This new introduction to the Code highlights, more succinctly and coherently than before, the basic concepts of ethics that are fundamental to the conduct of the pharmacist.

Part two: Standards of performance

Part two deals with the standards of professional performance that are expected from all members of the Society. Its two sections specify standards for professional competence and confidentiality.

These standards have been developed through the application of pharmacists' fundamental responsibilities identified in Part one, combined with basic ethical principles, to the two key aspects of practice that affect pharmacists' role

Competence

This section of Part two pulls together information that was covered by a large portion of the old Code, and replaces it with a shorter coherent approach.

Previously, professional competence was covered by Principle 5, the whole of Standard 7 in the appendix, and detailed advice in 'Good practice for ensuring professional competence'.

The new section comprises only a succinct, five-item list. This makes sense since the points listed are fundamental basic pointers to good practice. These will apply whatever the challenges that are brought to the profession in the next few years as clinical governance starts to impinge on the requirements and expectations of the pharmacist.

Confidentiality

The second Standard relates to the increasingly thorny issue of confidentiality. It takes the old Principle 4 and expands this to give greater guidance than before.

Expansion of the pharmacist's role brings more personal information about individual patients. So there are many aspects to confidentiality that might develop further in the next few years. In addition, patients are becoming concerned about their rights to confidentiality and the uses to which information held may be put.

This section gives pharmacists information about restrictions on divulging information and issues of security, particularly with regard to computerised information.

Part three

Also set out under two sections, Part three forms the bulk of the new Code of Ethics. Apart from an additional 19th Standard to the appendix there has been little change to the remainder of the old Code, which is set out in full as the new Part three.

The old Principles 1, 2, 3, 6, 7, 8, and 9 are set out in the first section. Issues include:

- advertising and promoting professional services
- relationships with other health care professionals
- concern for the patient and members of the public
- the honour of the profession and regard for the laws applicable to practice
- professional independence and judgement
- the premises from which pharmaceutical services are offered.

Section two, or the appendix, consists of the remaining 17 Standards from the previous Code along with the new Standard dealing with Internet based pharmacy services.

The future

The Ethics Working Party, in completely reviewing the Code of Ethics, has attempted to tackle the problems that exist and have grown with the old Code and to turn it into an empowering document.

For reasons beyond the Working Party's control, the full proposal was not ready to be put forward to the membership for adoption this year.

The Working Party will continue to meet to prepare further additions and/or amendments to the Code in line with the start already made.

Countdown to the new Code

May 1992 – The old Code of Ethics was adopted
Early 1998 – Council of the Royal Pharmaceutical Society decides to devise a new Code
September 1999 – Consultation document on a new Code published at the British Pharmaceutical Conference
February 2000 – Council agrees to amend implementation timetable so that only Parts one and two submitted to AGM in May. Working Party to continue working on Part three
April 2000 – Final version of new Code published
May 10, 2000 – New Code adopted at Society AGM
May 2001 – Further revisions of the Code to be presented to Council

This should result in a more sensible and understandable document that will enable pharmacists to carry out their role, in whatever branch of pharmacy, in a more professional manner.

It will, hopefully, be a Code that will sit at ease with, and reflect the requirements of transparency, accountability and competence that are demanded in many spheres of life.

Despite the problems in getting to this stage, the Code is still the means by which the Society issues guidance to members on what is considered acceptable behaviour, and it sets the standards against which behaviour will be measured.

It has attempted to identify and give prominence to the principles for which the pharmacist is expected to strive. These, if they have been properly identified, should relate to and be applicable to future developments in practice.

This format, once the full review has been completed, should result in an enabling Code that allows pharmacists to take control of their professional role. It will allow them to take advantage of new opportunities as they arise rather than hide behind antiquated prohibitions.

- *The new Code of Ethics is due to be published in 'Medicines, Ethics and Practice' in July*

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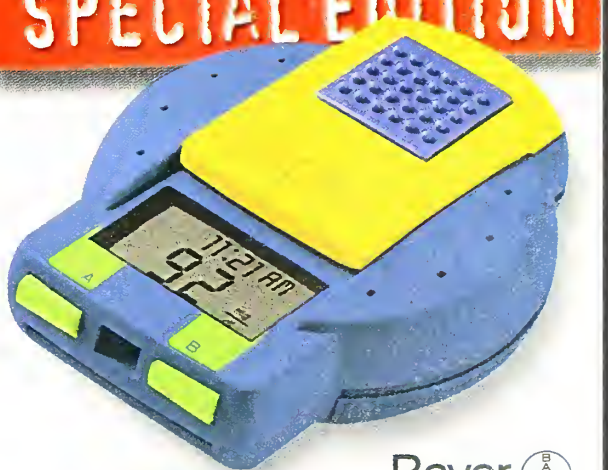

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Branch Reps meeting

EHC supply to pharmacies sparks heated debate

Supply of emergency hormonal contraception through pharmacies provoked a debate at this year's Branch Representatives meeting.

Reading Branch proposed that pharmacists should be able to provide emergency hormonal contraception, within an agreed shared protocol that could include suitable family planning advice. Charles Butler, proposing the motion, warned that, "if we don't grasp this opportunity, then somebody else will".

Pharmacists should be prepared to take responsibility for the supply, said Mr Butler. "We are pharmacists and should be proud to say so," he said.

Charles Butler, of Reading Branch, proposed that pharmacists should be able to provide EHC

Patient group directives are an ideal method of supply, said Mr Butler, because EHC could then be supplied free of charge. There is no evidence that pharmacist supply increases irresponsible sexual behaviour, he said.

Seconding the motion, Francesca Shearcroft, of Reading Branch, said: "We must expand the number of roles of services we provide and this is a good place to start. This is an opportunity we can't afford to miss."

President of the Royal Pharmaceutical Society, Christine Glover, who was chairing the meeting, pointed out that the Society had made a decision on EHC supply at its meeting the previous day. The Society's Council has decided to support a 'POM to P' switch, but wants to ensure that the product is free at its point of supply.

Mark Donaghy, of Bradford & District Branch, was against the motion that pharmacists should supply EHC

Bradford and District Branch opposed the motion, saying it is misleading to call the product a form of contraception when it acts after fertilisation. Mark Donaghy said: "We will be granting a carte blanche to men to pressure women into unwanted sex and an excuse not to use condoms." Mr Donaghy wants to see protocols in place for the supply of suitable POM medicines, but does not believe EHC is a suitable medicine.

Supporting this view, Janet Maynard warned that not all pharmacies have suitable counselling areas. She suggested that shops are not the place, and pharmacists do not have the time, to discuss sexual issues.

Summing up, Charles Butler acknowledged that some pharmacists will not want to offer the service, and there is protection in the Code of Ethics for these pharmacists. But he said, "we are a profession, let's grasp the ethos of the profession". The motion was carried.

Society PR

Leeds & District Branch proposed that the Society's public relations activities be assessed by an outside body. Murray Winer, proposing the motion, said: "There's an opacity that needs addressing" [at the Society]. While local Branch PR officers do a "great job", Mr Winer thinks that the central PR needs more continuity and a "slicker approach".

June Jenkins, from Cardiff Branch, warned that an outside body may not understand all the issues facing pharmacy. The motion was amended to remove the word "outside body".

Mike Burden, of Leicestershire Branch urged representatives to vote against the motion. He said the idea would prove too expensive, and an internal audit should be carried out instead. The motion was carried.

Publication of results

Jonathan Burton, president of the British Pharmaceutical Students' Association (BPSA), proposed a motion calling for the names of successful candidates from the Society's registration examination to be published in a national newspaper. This would raise the profile of the profession, said Mr Burton.

Murray Winer, of Leeds & District Branch, proposed that the Society's PR activity should be assessed by an external body

A figure of about £20,000 had been quoted to publish this list in *The Independent* or the *Guardian*. But since *The Times* would publish the list for free if they deemed it worthy, Mr Burton suggested the Society approach *The Times*. The motion was carried.

Council elections

South Cheshire branch proposed that a Council comprised of members elected on both a national and regional basis should be investigated. Bill Brookes, proposing the motion, said this would eliminate three current problems surrounding the elections.

There is currently a lack of knowledge about Council candidates, turnout at election time is low, and those on Council are out of touch with members interests. Locally elected

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Values discussion paper published

Prof Nick Barber: value judgements should be developed more

According to Professor Nick Barber, head of Centre for Practice and Policy, School of Pharmacy at the University of London: "The future of pharmacy depends on engaging properly with values."

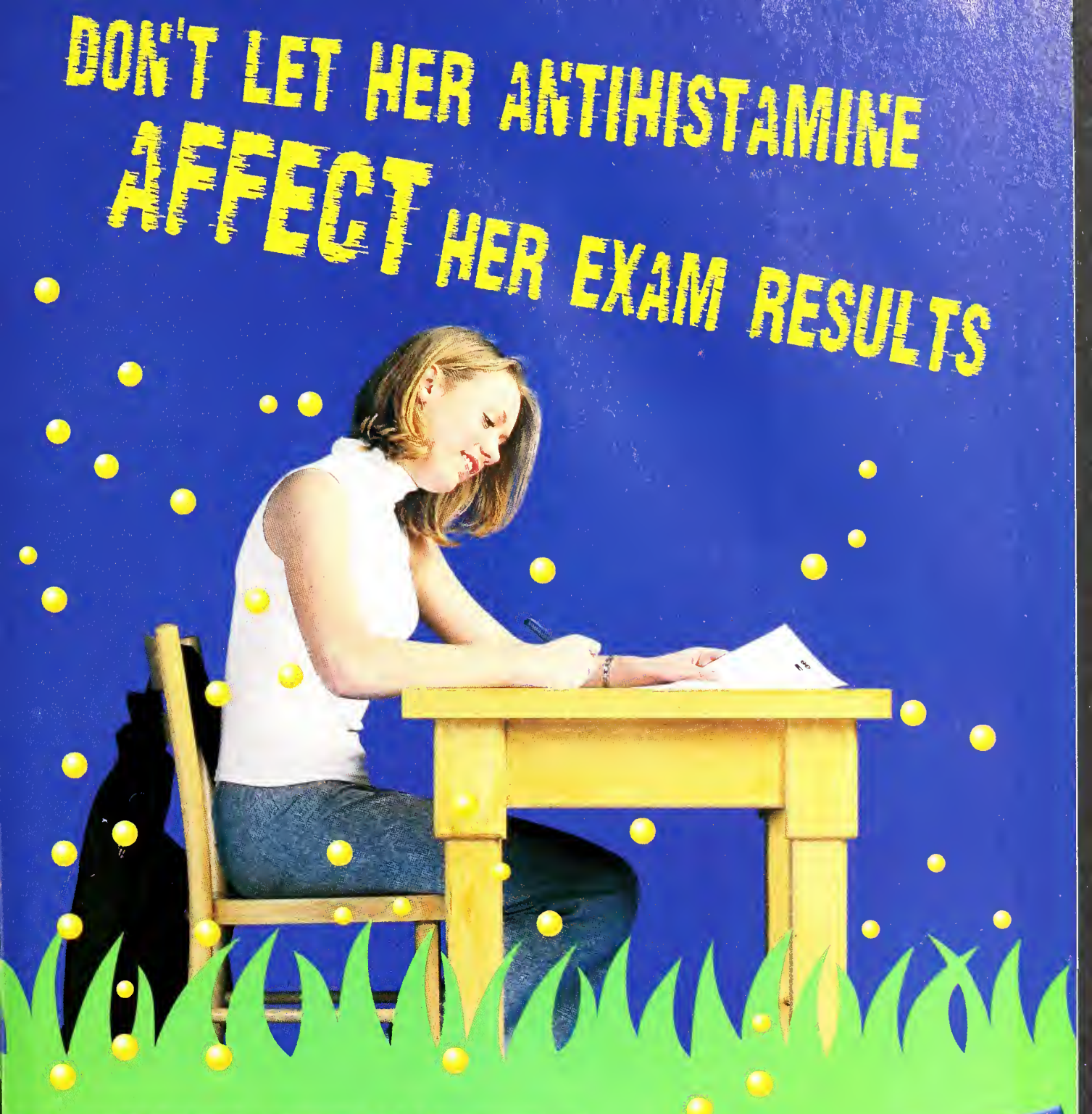
Introducing a new discussion paper, 'Developing pharmacy values: stimulating the debate' at last week's Branch representatives meeting, Professor Barber warned that a lot of pharmacy knowledge will become widespread with the increasing use of computers. He suggested that pharmacists should put more emphasis on "the hardest part of the job" – value judgements.

The discussion paper is designed to provoke debate. "It's something we want you to engage with," said Professor Barber. The key recommendation is that the case for developing pharmacy values and value literacy be subject to debate and consultation within the profession. It contains several specific recommendations:

- undergraduate courses in medicines, values and society – students should have the opportunity to study subjects such as bioethics, social theory and policy analysis
- fostering humanities and social science interdisciplinary postgraduate study and academic work – this would broaden the range of academic skills and research styles within academic pharmacy
- enhancement of continuing professional development – the aim would be to ensure that value issues form a recognised theme in CPD, and not just a limited 'stand alone' provision
- research is needed into students' and practitioners' perceptions and experiences of values and ethics, the institutions and cultures of pharmacy education, and the current place and future potential of pharmacy in public policy.

The document has been produced by the Pharmaceutical Society's Core Values Working Group, which was established last April by Hemant Patel. The group included Council representatives, Professor Stephen Denyer, head of Brighton School of Pharmacy, and Dr Alan Cribb, a moral philosopher.

DON'T LET HER ANTIHISTAMINE AFFECT HER EXAM RESULTS



It is well accepted that first generation antihistamines, such as chlorpheniramine and diphenhydramine, may frequently cause drowsiness.[1-4] But some second generation antihistamines are not without sedative risks. A recent post-marketing surveillance study involving 43,363 patients found that cetirizine and acrivastine were approximately 8.5 and 2.5 times ($p<0.0001$) more likely to result in reports of sedation, respectively, than Clarityn Allergy.[5]

In addition, a study in atopic children showed that untreated hayfever adversely affected learning ability and a sedating antihistamine exacerbated this. However, children treated with Clarityn Allergy showed superior learning performance to those treated with either placebo or a sedating antihistamine.[6] That's why it's important to recommend Clarityn Allergy, especially around exam time. Clarityn Allergy is a truly non-sedating antihistamine that can relieve all their hayfever symptoms[7,8] – without adversely affecting their exam results.[6]

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SCHERING-PLOUGH CONSUMER HEALTH

→Continued from P20

members would reduce these problems, but Mr Brookes did not exclude nationally elected candidates altogether. This motion was lost.

Presidential election

Weald of Kent Branch proposed that the President and Vice-President should be elected by an electoral college made up of the Branches of the Society.

Seconding the motion, Anthony Cox said that, "only a President elected by this system will have a clear mandate and be more accountable to the membership".

Tony Carson (South West Metropolitan) agreed with the motion, saying that, "Council has lost the moral right to elect the president. We must have a change".

Arguments against the motion were that it would take a lot of time and effort and not achieve much. And also that the President would be elected by a small number of active Branch members rather than the small number of people on Council. The motion was lost.

Single transferable vote

The single transferable voting (STV) system used to elect Council members was discussed, following Slough & District's motion at last year's meeting asking that Council reconsider the issue.

Roger Odd, head of professional and scientific support at the Society, reported that the issue had been discussed at Council's August meeting last year. A background paper was prepared and had been sent to all Branches in preparation for discussion at this BRM. The Health Act working party is currently considering the election system, and issued a consultation document in April.

Roger Mills (Slough) said that the STV system is suitable for electing one member of Council, but not when there are seven to be elected. But he now believes that it does not make a big difference to the end result if the STV or the "seven crosses" (7X) system is used. He called the decision a "judgement call", which probably has no completely satisfactory solution.

Nicholas Wood (Chelmsford & District) called for other potential voting systems to be discussed. "It's not a simple choice," he said.

Bill Brookes spoke in favour of the 7X system. "Let's go back to something we understand," he said.

Elizabeth McConechy (Glasgow & West of Scotland) pointed out that the Society's Scottish Executive is still elected with a "cross system" and they still have the problem of a "falling vote".

RPSGB AGM

AGM adopts Parts 1 and 2 of new Code

Parts 1 and 2 of the revised Code of Ethics were adopted at this year's Annual General Meeting, along with Standard 19 dealing with information technology.

However, Bill Darling, chairman of the Ethics Working Party asked that Part 3 of the new Code not be put for adoption until next year's AGM.

Part 1 of the Code replaces the existing Preface which will be deleted. Part 2, dealing with professional competence and confidentiality replaces the existing Principles 4 and 5 and Standard 18 which will be deleted.

Rather than wait until next year to agree the new code in full, Mr Darling said that there was a need to demonstrate that practicing pharmacists are keeping up to date. "There is a need for Council to make a public declaration of intent of the key responsibilities of the pharmacist," he said, referring to the developing attitudes of the Government, other health professions and patients over clinical performance.

Andrew Harrison of Hull objected that the meeting was being asked to accept the new parts of the Code, despite not having enough time to consider them properly.

"There have been some quite significant changes," he said. "While I support the revision of the Code, this is not the way to go about it. Shortness of time may be an explanation, but does not excuse it."

Mrs Glover commented: "It is important that the membership understands that there is an extreme urgency to be seen to be getting our house into the best possible order."

Standard 19 has been adopted as an interim standard and will be under review for the next 12 months. The revised standard will then come before next year's AGM with Part 3 of the Code.

Bill Darling: Code is a public declaration of intent

IT could impact on Society's finances

Treasurer Gordon Appelbe warned that information technology could impact heavily on the Society's income.

Setting out his annual report, Dr Appelbe explained that membership and premises fees represent only a quarter of the Society's income. A much more significant part, 56.5 per cent, comes from publishing activities. "There is a worry concerning the potential effect that e-commerce may have on the Society's publishing activities," he said. "The Council is already considering this as a matter of urgency."

The 32nd edition of Martindale had dominated the financial results, helping the publication directorate to achieve revenue of £11.5 million against expenditure of £9m.

However, the balance sheet had a deficit of £75,000, "which was better than the budgeted deficit target of £300,000 set by Council in 1998", he said. Expenditure supported practice research, which increased 108 per cent to £522,000, and public affairs spending went up by 67 per cent to £491,000. Overall professional activity costs were up 15.4 per cent at £12.7m.

Following previous years' concern over accountability, transparency and probity of expenses, Dr Appelbe announced that an audit committee will be set up. This will have the authority to investigate any activity it deems appropriate and will have the power to engage the advice of lawyers, accountants or other professionals as the committee sees fit.

Salaries at Lambeth went up £500,000. This represents increases of 5 to 6 per cent for secretarial staff and slightly more for management. There was also an additional 3 per cent allowable for merit and performance related awards.

Other expenditure was incurred with increased lobbying of the Scottish Parliament and Welsh Assembly.

The officers of the Society (from left): treasurer Gordon Appelbe; vice-president Marshall Davies; president Christine Glover; and secretary and registrar Ann Lewis

Branches get internet pages

The Society has allocated each Branch dedicated space on the Society's web site.

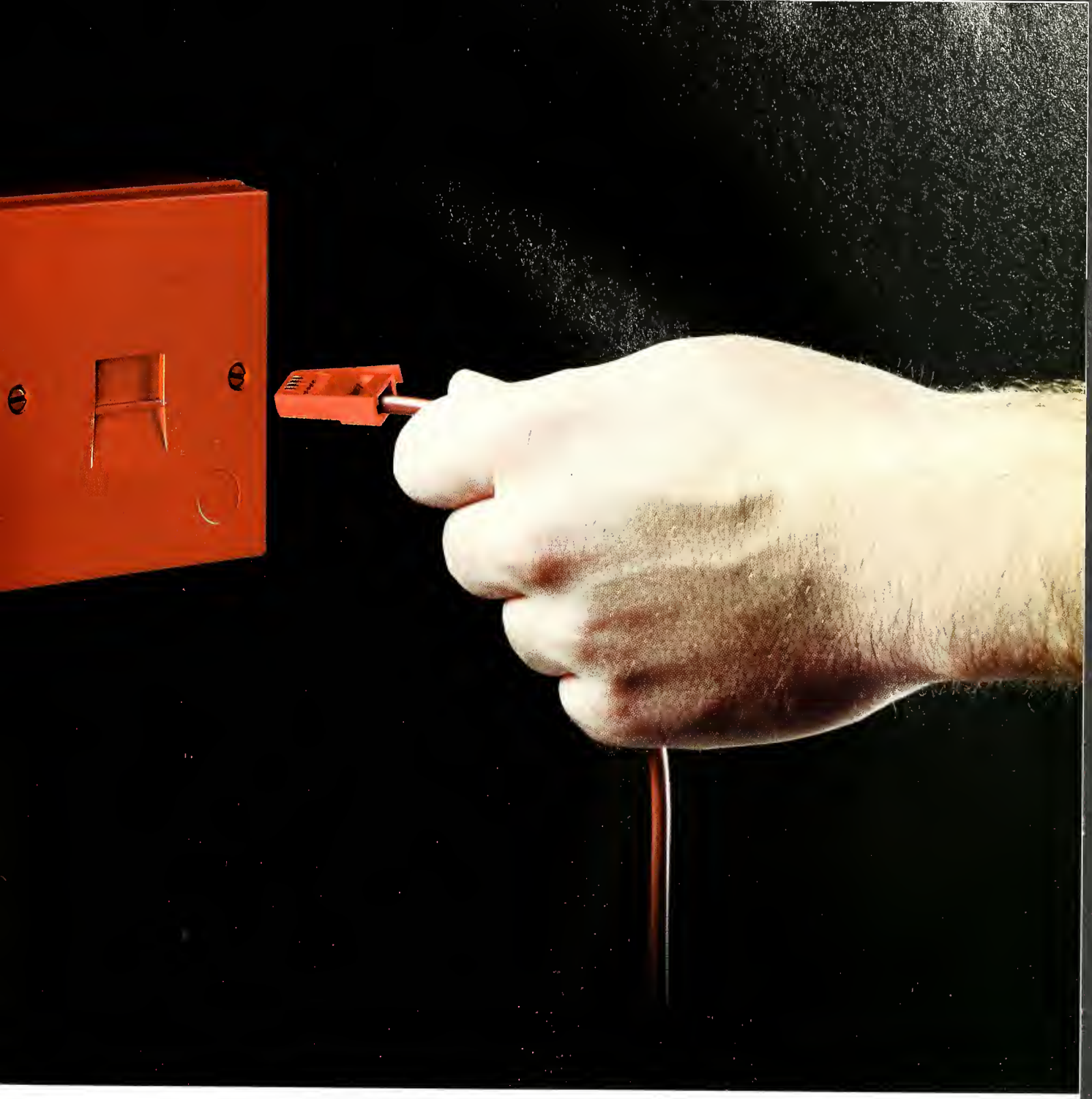
By being part of *www.rpsgb.org.uk*, the Society hopes that information will be located more readily. It provides an index and search engine, with no hosting charge. Branches are expected to provide information on contacts, a diary of events, Branch news and special announcements.

The pilot will last until the end of June with no links from anywhere else on the Society's web site to the trial Branch webspaces. During that time members can see their webspace at: *www.rpsgb.org.uk/branches/[your-directoryname]/branchhome.htm*

Further information is available from Mary Snell on: *msnell@rpsgb.org.uk*.

New Council Code

The new Code of Conduct for Council members will be voluntary to start with, said Mrs Glover, as there is a need to ensure it is "tweaked" correctly before it goes into the byelaws, making it easier to enforce. There will also be a register of members' interests. The Society intends to publish the names of those who have and those who have not signed the Code.



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Lloydspharmacy sees many opportunities in an age of e-commerce and primary care groups, but not at the expense of independent pharmacists. Guy L'Aimable reports

Community concerns

Two of our biggest pharmacy chains have very different attitudes to e-commerce. Boots the Chemists is piloting an on-line store which sells selected OTC, mother and baby and toiletry lines. Lloydspharmacy, in contrast, believes on-line pharmacy-to-consumer is a non-starter and is not even interested in forming 'clicks and mortar' link-ups with existing pharmacies, as is already happening in the more mature US market.

These diametrically opposed strategies partly reflect the chains' different images. BTC is a high-street specialist, whereas Lloydspharmacy sees itself as a 'community pharmacy chain', albeit one with more than 1,300 stores. And, like many independent community pharmacies, the chain is encouraging customers to see its pharmacists as healthcare counsellors. It has arguably taken the concept a step further with its social pharmacy theme, which aims to prevent customers falling sick in the first place by addressing their social/economic problems. Its pilot health and wellbeing centre in Sandy, Bedfordshire, officially opened on May 5 and is exploring new ideas on this front.

Michael Ward, Gehe UK's chief executive and *de-facto* managing director of Lloydspharmacy, says the internet offers far more opportunities as a source of information. Lloydspharmacy's outlets are set to have their own healthcare web site, which will contain practically all the information their customers need (AAH Pharmaceuticals is preparing a similar web site for Vantage members).

The chain's pharmacists and pharmacy managers, meanwhile, will benefit from an £18 million EPoS system currently being developed. Its features will include a communication infrastructure which will improve dialogue between the stores. "All this will enable us to provide them [pharmacists] with better and relevant training. We don't have to surf the net for it – we've got a very good training department that can select pieces for our staff and make sure that they can access all the relevant information," says Mr Ward.

Lloydspharmacy can afford to distance itself from e-commerce – for now – because it is in a relatively strong financial position. Its turnover rose 20 per cent to £787 million last year – NHS sales were up 22 per cent to £603 million, while OTC sales rose 14 per cent to £184 million. Gehe UK's interest payments last year were also lower than in 1998.

By the end of this year, the chain expects to have 500 rebranded outlets and aims to complete 150-200 next year. It had budgeted £20 million to rebrand 250, but Mr Ward admits the process is taking a little longer than anticipated because of the logistics involved. Rebranded stores are performing much better than traditional Lloydspharmacy outlets. How much better? "Let's put it this way, they're performing sufficiently well to pay for the refits," he says.

"Our aim is to collaborate with independent community pharmacists – not grind them down"

The rebranded outlets' NHS to OTC split is 75:25, broadly the same as other Lloydspharmacy stores.

Mr Ward says the chain's emphasis on NHS/OTC products has left it largely untouched by the supermarkets' toiletry price war. It has offered selected toiletry discounts as an added precaution, but its stores trade on convenient locations and reasonable prices, not huge discounts. Which is why its like-for-like toiletry sales are said to be growing, while the toiletry market in pharmacies is declining by up to 10 per cent.

The chain has around 150 stores in health centres and expects another 40-50 outlets to become involved by the end of next year.

Michael Ward: mutual interest with independents

Health centres obviously improve the pharmacies' script business, but the outlets perform less well on OTCs. "That's quite a trade off and its usually a difficult decision [to move into a health centre]. But we don't do it unless its more profitable for us," he says.

While Lloydspharmacy still wants to acquire more pharmacies, Mr Ward stresses its aim is to collaborate with independent community pharmacies – not grind them down.

For example, the chain is prepared to let some of its outlets join forces with Vantage pharmacies, and other independents, to form groups that could bid for primary care organisation contracts. Mr Ward says the chain's excellent reputation for formulary management, allied with that of AAH, would give their independent colleagues a strong negotiating base.

The chain, of course, will bid for PCO contracts alone in other geographic regions.

Mr Ward would like pharmacists to be paid for the services they provide to primary care groups, which should

e given enough money to pay them dequately. "Its in those areas that we hould try to put creative ideas to overnment to get new funds," he says.

Has Lloydspharmacy suggested any deas to the Government? "We'd only o it through the various [pharmacy] rganisations because we don't want o be seen as yet nother splinter roup. Its got to be onsistent and oncerted, and if 've can work with ae NPA and the SNC, we will."

As with other eading pharmacy gures, Mr Ward elieves the level of ay for NHS harmaceutical ervices is pitiful. here are a number f areas where overnment could save a lot of money y working closely with pharmacists. ut the question is whether it would ay pharmacists for counselling, or for onitoring drug usage. Will it attribute avings in its cost base to pharmacists nd allocate them a proportion of this oney as a reward?

Mr Ward agrees these questions ave been asked before, but that does ot mean you should stop asking hem. "Like most things in life you've ot to carry on – you must never give up. If everyone tells the Government it is throwing away £1 billion in drugs, one day it is going to say 'how are we going to stop this?' "

Pharmacists are the only people, not GPs, he adds, who can monitor whether patients have picked up their prescriptions, and whether they have gone back for repeat prescriptions.

> **"Pharmacists are the only people who can monitor whether patients have picked up their prescriptions"**

Every pharmacy group and independent – not just Lloydspharmacy – should lobby the Government on these issues. "The more we can speak with one voice, as opposed to having several voices, the better it will be. The reason the Government doesn't listen is that it is besieged by too many voices," he says.

This is a long standing complaint about the pharmacy sector. What makes him think pharmacists can achieve this co-ordination now? "At some point everybody has got to realise that it isn't 'big bad chains' sitting on one side and the independents on the other. We've got a mutual interest and as soon as people start to realise this the better – it's one of the reasons we joined the NPA, we wanted to be part of it, rather than sitting outside looking in," he says.

It is clear Lloydspharmacy's image is radically different to the 'old days', under former chairman Allen Lloyd, when it was considered a difficult chain to work for.

Mr Ward says the chain's improved training programme, working environment and staff terms of conditions has helped it to weather some of the recruitment problems highlighted by the recent Institute of Pharmacy Management survey (*C&D*, April 8, p38).

But he admits the situation is still difficult, although the problems tend to be geographic. For example, Lloydspharmacy outlets near pharmacy schools have full employment, whereas elsewhere it is harder to find staff. "The situation is also aggravated by a lot of people who want to work as locums permanently now – we have almost permanent locums in a large number of stores. These people like working for you, but they want the flexibility, occasionally, to work for somebody else," he says.

Lloydspharmacy has not closed stores due to a lack of pharmacists, although it might have closed one or two outlets for a couple of days this year because of the shortage.

Mr Ward says it would be a mistake to increase salaries and conditions to recruit more pharmacists. "Its a vicious circle. If we increase the salaries, the independents will increase theirs – are we really going to be better off then?"

You could argue multiples are in a much better position to win a war of salaries, but Mr Ward says that is a flawed strategy. "Our job isn't to price out independents, it is to work with them because we don't want them to be short of pharmacists. We have a rate for the job, we're prepared to pay that and we're going to have to work hard to manage it. That s the message our area managers get," he says.

Lloydspharmacy recruits only a fraction of its pharmacists from abroad – most come from its pre-reg process. People come to the chain, according to Mr Ward, because they know they will work in a community, not in a huge great high street store. They will get the best training and they'll come out of it with the potential of getting the highest pass rate. Lloydspharmacy, he adds, has the highest pre-reg pass rates every year.

Presenting a quality package to both staff and consumers is the chain's core criteria. In the near future Mr Ward wants consumers to automatically think of its outlets if they need guidance on healthcare. "I want them to think Lloydspharmacy is the clear leader in this segment. If we can achieve that we'll overcome all of the threats we see on the horizon."

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Moss acquires all Scholl outlets

Moss Pharmacy has expanded its interests in the chiropody and footcare market by acquiring SSL International's Scholl retail business for around £3 million.

Scholl has 57 outlets in the UK and Ireland and concentrates on chiropody services, footcare and footwear. It will be renamed Scholl Footcare Centre.

Barry Andrews, Moss' managing director, said the chiropody/footcare market was an ideal source of new revenue: annual sales have ranged between £300m-£500m and Scholl has 10 per cent of the market.

Moss will widen the range of services and products within the Scholl outlets, which currently stock only Scholl products. Other footcare brands and sports injury lines will be introduced.

Mr Andrews said Scholl will concentrate on the healthcare element of chiropody. "We're not going down the Boots route which, as I understand it, is in the pampering market," he said.

Moss' first aim is to expand the Scholl chain and it will review the business to see where the opportunities lie, though it was too early to say how many shops Scholl will want to acquire. The review will decide if new fascias and shop layouts are needed.

The next stage is to introduce 'mini Scholl' shops, which could have one or two chiropodists, in Moss outlets. Moss believes the demand is already there because the chiropodists it currently offers are extremely popular. "Some people have to wait three months for their chiropody appointment," Mr Andrews admitted.

If the mini-Scholl concept works, he added, it could be offered to independent pharmacists.

Meanwhile, Moss will bring in a managing director to run the chain; other management will probably be recruited from within Scholl.

SSL will retain an interest in the business and will produce Scholl products for Moss, receiving undisclosed royalties based on the products' sales.

Iain Cater, SSL International's chief executive, said it sold Scholl to concentrate on its core businesses, which include manufacturing and distributing footcare products. "We are not retailers so it makes good sense to hand that aspect over to Moss, who are retailing and healthcare experts, while we continue to have an expanding outlet for our products," he said.

- Pharmacists could play a key role in ensuring that patients keep taking long term medication, according to research involving Moss Pharmacy.

From left: Rob Darracott, Moss Pharmacy's professional services executive, Sue Rockhill, marketing director, and Barry Andrews, managing director

The project, funded by NHS North Thames, is examining the needs of chronic sufferers given regular medication for the first time. It is led by Nick Barber, professor of pharmacy practice at the London-based School of Pharmacy, and research fellow Jim Parsons.

In the project's first phase, pharmacists in 26 Moss outlets recruited 272 patients receiving long term therapy for the first time. Ten days after they were recruited, a researcher called each patient to check their compliance and to find out what information they needed. The findings were that:

- within a few days, 22 per cent of the patients had missed taking their new medicine at some stage
- nearly one in three patients had failed to take any medicine
- out of patients who had not taken their new medicine, 42 per cent said they had forgotten to do so
- 34 per cent said the medication disrupted their routine
- 23 per cent said they had not taken it because of side effects
- 19 per cent cited other reasons
- 2 per cent said the treatment was too complicated.

Patients said they wanted more information about how to use, and take, the medicine; what the treatments were for; how they worked; and what side-effects could follow. Pharmacists scored high as a general reference score and were rated third behind GPs and written material as a "useful" source of information; which suggests pharmacists still have some ground to cover to convince the public that they make ideal healthcare advisors.

During the second stage of the project pharmacists will phone the patients, and the effectiveness of this intervention will be assessed.

Barry Andrews, Moss' managing director, said patient compliance was a key issue, since non-compliance accounted for up to 50 per cent of the NHS' £5 billion drugs bill.

Rob Darracott, Moss' professional services executive, said the telephone interview system seemed ideal for checking compliance and identifying patients' needs: "The indications already suggest a number of ways in which pharmacists may be able to improve outcomes for patients, from responding directly to these new information needs as they are identified, to providing reminder devices or formalising feedback to GPs."

- Moss Pharmacy will pilot a Total Health store this year. Features will include a wider healthcare range, including alternative remedies, extra-fast dispensing, private counselling, disease management, rentable consultancy rooms, and health promotions linked to local healthcare initiatives.

Meanwhile, Moss' traditional format, at E Moss in Northallerton, North Yorkshire, is said to have been an outstanding success. Another ten E Moss outlets are expected to be launched this year.

IN BRIEF

UniChem offers discounts on single items

UniChem is offering pharmacists discounts on single items during June. It said the promotion would save pharmacists having to find extra room to store products, and they could take advantage of promotions on medium or slow moving lines, which they may not normally stock or order in bulk.

Nucare share prospectus

Buying group Nucare will issue its share prospectus on May 22. If the issue proves popular, Nucare members may be given priority on buying the shares.

PCG Holdings extends float deadline

Primary Care Group Holdings, the Nuneaton-based firm that provides IT services to the NHS, has raised £1 million by floating on OFEX and has decided to extend the offer to potential investors until June 2. Chairman, Terry Richardson, said the extension made sense because of the enthusiasm of private investors.

Health and beauty website

A website offering advice on nutrition, beauty and personal fitness – *www.VitaGO.co.uk* – has been launched by Munich-based VitaGO AG. The site also offers on-line shopping over four categories: medical care, beauty and personal care, baby and child, and healthy living. Customers can choose from around 10,000 branded products. VitaGO AG has set up similar sites in Germany, Italy and France.

Axis-Shield appointment

Axis-Shield has appointed Paul Garvey as group finance director and he will take up his post on August 1. He was formerly group managing director of Lindsay Plant, a business service group based in Scotland.

COMING EVENTS

MAY 24

Slough & District Branch, RPSGB, at Stiefel Laboratories Ltd, Holtspur Lane, Wooburn Green, High Wycombe, 7.30 for 8pm. Annual general meeting.

MAY 25

Bedfordshire Branch, RPSGB, at Silsoe College, 7.30 for 8.00pm. 'African Impressions' by Les Robertson, chairman.

MAY 27

Edinburgh & Lothians Branch, RPSGB. Millennium Ball at Roxburgh Hotel, Charlotte Square, Edinburgh.

AAH rolls out a stand for all seasons

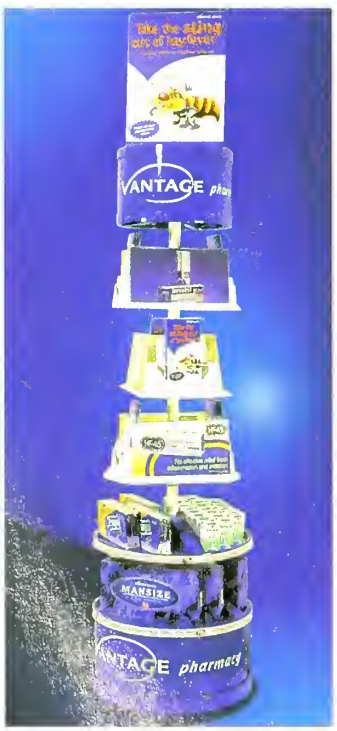
AAH Pharmaceuticals has launched a Vantage seasonal medicine display stand which gives customers information about P-medicines and suggestions about products linked to seasonal ailments.

The stand is partly designed as an aid to pharmacists, who may be unavailable or too busy. Its seasonal theme calendar covers hay fever and allergies from May to August, the back-to-school period from September to October, and coughs and colds from October to February.

Levels one to three on the stand feature P product information and general information about top-selling seasonal lines; levels four and five present GSL products and offers supporting the seasonal theme.

AAH will also provide merchandiser support, PoS material and trade promotional packages.

Pharmacists can acquire the stand for £40 by contacting Christine Morris, Vantage brand manager, on 02476 432000.



ABPI attacks Prodigy's anti-migraine choice

The pharmaceutical industry has criticised Prodigy, the Government-endorsed computerised prescribing system, for offering only one type of anti-migraine drug when there are several others available that could work better on some migraine sufferers.

A report commissioned by the Association of the British Pharmaceutical Industry, 'Target Migraine', says the triptan class of medicines are the most selective and useful for treating acute migraine.

Prodigy recommends Glaxo Wellcome's Imigran (sumatriptan), but fails to list three relatively new products: GW's naratriptan, AstraZeneca's zolmitriptan and Merck Sharpe & Dohme's rizatriptan.

'Target Migraine' says patients should be offered a choice of all four products "because without it patients and doctors would have less choice and fewer people would achieve acceptable control of their illness".

Dr Trevor Jones, director-general of the ABPI, said migraine occurs in different forms and affects sufferers in different ways – which is why patients should be offered a wide range of treatments. "It really is quite absurd that migraine patients should have to go through further pain to get the medicine that is right for them," he said.

Migraine, according to the report, costs the UK around £712 million a year as sufferers take time off sick from work, or work less efficiently. The anti-migraine drugs bill is around £37m a year and the report says a wider choice of medicines would greatly reduce this financial burden.

The Department of Health said the three recently introduced treatments were still under close observation for unsuspected or adverse reactions. When the drugs have been on the market long enough, Prodigy's guidance will be reviewed and a decision taken on whether to recommend them.

'Target Migraine', which also explains what causes migraine and the steps pharmaceutical manufacturers are taking to combat it, is available free from the ABPI's publications department, tel: 020 7930 3477 ext 1446.

Boots to offer laser hair removal instore

Boots is to set up laser hair removal clinics in seven of its stores in September.

The clinics will be set up alongside existing dental and chiropody services and have been approved by the appropriate health authorities. Nurses will be operating the diode laser systems, with a consultant dermatologist overseeing the service.

Rather than offering permanent hair removal, a Boots spokeswoman said it should be regarded more as a 'hair management' service. Treatment normally lasts between four and eight sessions, with an expected 40 per cent reduction in hair growth. The laser method works by energising the pigment melanin in the hair, causing the follicle to explode.

Appointments will last from about 15 minutes for armpits to one and a half hours for both legs. Although no definitive price structure has been agreed, the fee may be around £40 per quarter-hour session.

In another development, Boots said it plans to set up US-style nail bars offering customers a walk-in manicure service. It will be launched in seven stores from September, in London, Milton Keynes and Manchester.

Boots also announced that its internet site will offer a range of products not available through its stores. These include cosmetics, fragrances, sports and exercise equipment, and Speedo fitness wear. The Boots web site is at *www.boots.co.uk*.

Glaxo/SmithKline to axe seven sites and union braces for 5,000 job cuts

Glaxo Wellcome and SmithKline Beecham will close seven administrative sites in the UK during post-merger restructuring.

The sites affected are SB House and New Horizons Court in Brentford, plus its facilities at Mundell, Welwyn Garden City. GW's leased facilities in Slough, Ealing Broadway, Southall and Stockley Park Lakeside, will be closed after Glaxo SmithKline has built its new headquarters in Brentford, Middlesex, expected to be ready in autumn 2001.

Glaxo SmithKline's UK pharma company will be based at Stockley Park, and GW's corporate head office in Greenford, Middlesex, will become an R&D centre.

Neither company was prepared to comment on how many administrative jobs will be axed during the restructuring, although the Manufacturing Science and Finance Union estimates that the final tally, including manufacturing employees, could top 5,000 in the UK.

According to both companies, the three administrative UK locations are a logical solution, partly because they are close to each other and to good transport and communication links, such as Heathrow airport and central London.

PMI launches bespoke cover for locums

A professional indemnity insurance package for locums has been launched by Pharmacy Mutual Insurance in association with Avon Insurance.

The package provides professional indemnity and public liability cover of up to £1.5 million, plus legal defence cover which includes taxation protection. Locums will have access to 24-hour confidential helplines for advice on tax issues, and for counselling.

PMI said the package reflected the increasing number of pharmacists who prefer locum work. The cover supported the RPSGB's ethical code.

"We fully recognise that the indemnity and defence benefits offered by the NPA extend to NPA members and anyone they employ or engage," said a spokesman. "However, there are locums who want the added peace of mind associated with having their own personal policy." More information is available via PMI's indemnity insurance quote line on 0800 216118.

ADVANCE INFORMATION

May 30 to September 5. AAH Pharmaceuticals 2000 Golf Tournament. The Vantage Scholl Golfer of the Year Tournament will be held at different venues across the country. The overall winner will be entered in the *Daily Telegraph* Business Golfer of the Year competition, courtesy of Scholl. The golf dates are: **May 30** – Belvoir Park, Belfast; **July 5** – Dalmahoy Kirknewton, nr Edinburgh; **July 20** – Coldra Woods, Newport, Gwent; **August 9** – Hollins Hall, Shipley, West Yorkshire; **August 24** – Golf Drive, Camberley, Surrey. The Final will be held on **September 5** at The Belfry, Warwickshire. For further details, contact Nathalie Craven or Rae-Anne Gardner on 0161 437 4474.

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PSNI raises £1,000

The Pharmaceutical Society of Northern Ireland raised £1,000 at its annual ball last Saturday at the Templepatrick Hilton. The money will go to Action Research, the charity nominated by the president, Professor James McElnay.

The ball comes in the Society's 75th anniversary year, and the 125th year of the Pharmaceutical Society of Ireland. In October a joint event is planned to celebrate the anniversaries, said the president. Although, not an occasion for speechmaking, Prof McElnay took the opportunity to publically welcome the new chief executive, Sheila Maltby and thank Joe Gault for standing in as secretary following the retirement of Derek Lawson.

On the political front, Prof McElnay hoped the second attempt at devolved government would proceed quickly and "stick this time around". He looked forward to working with the PCC in the coming months to promote pharmacy to local government. His other priority, he said, was to move forward with the implementation of the Society's Vision 2020 initiative.

PSNI officers present and past (left to right): the new chief executive Sheila Maltby and her husband Des, past secretary Billy Gorman, Sandra Lawson, Dorrie Gorman and the immediate past secretary Derek Lawson

Liz Kerr (left) with husband and PSNI Council member Brendan Kerr, with UCA president Fiona Harte and her husband Seamus Walsh

Twelve minutes off the Olympic qualifying time...

Not only did a surprisingly large number of pharmacists run in the London Marathon before Easter, but some of them did really rather well. Terry Field of Vantage Chemist in South Kirkby, Pontefract, is the latest to reveal his talents. He came in 58th in a time of 2 hours, 27 mins and 17 sec (you can tell its getting serious when they start to worry about the seconds).

Our Terry, who runs with Barnsley AC, is a late comer to athletics, having only taken up the sport just over two years ago, more because his wife started running than anything else. His thoughts are already on next year's event, when he hopes to run under 2 hours 25 mins. It'll be his last chance before he becomes a veteran, although they do say for some life begins at 40.

Back issues

Rule Britannia!

At the turn of the last century, Britain was still considered 'Great', and ruled over an impressive empire. To reflect Britannia's global influence, *C&D* carried news from India, Australasia, France, South Africa, and any of its colonies that practised pharmacy. It also carried weekly updates on the Boer War.

Any *C&D* subscribers whose places of business were in the Transvaal and Orange Free State and had not received their magazine since war broke out were advised to contact the publisher. Copies had been kindly reserved and would be sent to the subscribers' new addresses.

Our Johannesburg corespondent reported in May 1900 that 'enteric fever and dysentery are responsible for far more deaths than Boer bombs and pom-poms and murdering Long Toms, or pattering Mauser hail. There are 8,000 sick troops in the Natal hospitals.'

Mr W N Cooper wrote to *C&D* to say he was pleased to have received all his magazines to date after getting besieged in Kimberley. He was relieved to have escaped the siege without any damage to his property and reported that pharmacies had been well stocked and did not increase prices. Calcium chloride and artificial limejuice were used to treat scurvy.

However, the inhabitants of Bloemfontein were not so lucky. The *Bloemfontein Friend* reports: "More than one druggist lacks material for making up prescriptions – disinfectants, ginger, zinc oxide, blue ointment, acetate of lead, and iodoform. Beecham's Pills were 'all out' four months ago."

Feelings were running high in this country. A Mr J F Brown had his Dover pharmacy wrecked by a mob after rumours suggested that he sympathised with the Boers. It took over 100 soldiers to restore order at his pharmacy.

There was news from Ireland that the Portadown dispensary had insufficient shelf space for its 5,000 bottles of medicine. Many of the stock bottles had to be kept on the floor and were felt to be in danger of being kicked over by people having their teeth extracted. As a result, the Dispensary committee refused to issue orders for tooth extraction.

A 'Miscellaneous inquiries' section offered these gems of wisdom:

- the way to keep flies off a looking glass is to provide a counter-attraction for them in the shape of fly reels, papers or catchers
- the colour of tripe is improved by soaking in milk of lime
- grease paint for imitating the colour of the skin of the North American Indian – this is made by mixing levigated yellow ochre and brown umber with Vaseline and hard paraffin.

Perhaps more telling was the Jeremy Paxman-style put down to silly questions:

- the pill box in which you sent the 'parasites' was smashed when it reached us, and its contents gone; but please do not send a further supply as it is of no interest to our readers to identify them
- we take the letter to be a bit of humour
- we do not care to prescribe for your cold
- thanks for your letter; but a discussion of a cycle tax and the formation of a special section of public highways for cyclists would not be suitable for *C&D*.

A number of young dispensers from all over the UK, but mainly from Northern Ireland, pose for *C&D* before leaving for South Africa and the Boer War

Pharmacy service AWARDS 2000

CHEMIST & DRUGGIST

GlaxoWellcome

You know you provide your customers with a good pharmacy service. This is your chance to prove it and walk away with a prize of £1,000 to further improve customer services

The Pharmacy Service Awards seek to recognise and reward the excellent pharmacy service given by individual pharmacies – both independents and multiples – to their customers.

We are looking for examples of pharmacies that make a special effort to meet their customers' healthcare or shopping needs.

Your pharmacy might, for example, place particular emphasis on training and customer care to give an extra dimension to the shopping experience.

You might go out of your way to cater for 'special needs' shoppers. You might specialise in a particular area, such as babycare or sports medicine.

You might offer particular pharmaceutical services, such as regular clinics, or customer-focused health promotion schemes. You may offer an extended delivery service or a medicines management scheme in conjunction with a local surgery.

You may display medicines or health information leaflets in a particularly customer friendly way, or cater for mothers with children or the disabled, with wide isles and easy access.

Examples can be given of up to three unique 'selling' propositions or initiatives which contribute to providing your customers with a quality pharmacy service and shopping experience.

For each example you should detail:

- what is the 'USP' or service which your pharmacy offers
- what is the rationale or aim of the service
- how has the service been developed or put into practice
- what it delivers both to the pharmacy and the customer.

For both multiples and independents

The Awards are open to both independent and multiple pharmacies. In each category the winning entry will take away a prize of £1,000, and the runner-up £500.

Entries should be no longer than 1,500 words, and may be supported by pictures, testimonials from customers, leaflets etc. They should reach this office by May 31.

The Rules

1. Any pharmacy registered in Great Britain, the Channel Islands, the Isle of Man or Northern Ireland is eligible for entry.
2. Closing date for entries is May 31. The Award winners will be announced in *C&D* on October 7. Individual winners will be notified by July 28. The awards will be presented at a lunch to be held in London on September 21.
3. Entries will be placed in two categories
   - independents (single pharmacies or groups with no more than four shops) and
   - multiples (groups with more than five branches)
4. The winning entry in each category will receive a prize of £1,000, and the runner-up £500.
5. Entries must be typed or printed, and be accompanied by the entry form (right).
6. The entry and any supporting material (eg photos, practice leaflets etc) may be published within *C&D*.
7. Entries will be judged by a panel of five judges chaired by *C&D* Editor Patrick Grice.

Please complete the entry form and attach it to the front of your submission. Send your entry, to arrive no later than May 31, to:

Pharmacy Service Awards 2000, *C&D*, Miller Freeman House, Sovereign Way, Tonbridge, Kent TN9 1RW.

Name of person submitting entry.....

Position.....

Pharmacy address.....

.....

.....

.....

.....Post code.....

Phone number.....

Contact name (if different from above).....

.....

Company name (if different from above).....

.....

Category (please tick): Multiple ☐ Independent ☐

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For the treatment of verrucas, warts, corns and calluses

- Uniquely formulated, clinically proven treatment
- Dries to form a water-resistant, protective barrier
- Designed to inhibit spread of the verruca/wart infection
- No plasters necessary
- Simple, once-daily application

PHARMACY ONLY

Extra strength treatment for verrucas and warts

- Uniquely formulated extra strength treatment
- Dries to form a water-resistant, protective barrier
- Designed to inhibit spread of the verruca/wart infection
- No plasters necessary
- Simple, once-daily application

bazuka™ Gel

for the treatment of verrucas, warts, corns and calluses

EXTRA STRENGTH

bazuka™ Gel

Extra strength treatment for verrucas, warts, corns and calluses

salicylic acid, lactic acid

salicylic acid

NO NEED FOR PLASTERS

BAZUKA Trademark and Product Licences held by Diomed Developments Ltd, Hitchin, Herts, SG4 7QR, UK. Distributed by DDD Ltd, 94 Rickmansworth Road, Watford, Herts, WD1 7JJ, UK. **Indications:** For the tre of verrucas, warts, corns and calluses. **Directions for use:** For adults, the elderly and children: Once daily apply one or two drops of the gel to the lesion and allow to dry, taking care to avoid the normal surroundi The following day, carefully remove the dried patch and apply fresh gel. Once every week, before re-applying fresh gel, gently rub the treated surface using the emery board provided. Continue treatment until the condit resolved. This may take up to 12 weeks for certain verrucas and warts. **Contra-indications:** Not to be used on the face, neck, intertriginous or anogenital regions, or by diabetics or individuals with poor blood circ Not to be used on moles, birthmarks, hairy warts, or any other skin lesions for which the gel is not indicated. Not to be used in cases of sensitivity to any of the ingredients. **Precautions and Warnings:** Keep away fr eyes, mucous membranes and from cuts and grazes. Avoid spreading onto normal surrounding skin. Do not use excessively. Avoid inhaling vapour and keep cap firmly closed when not in use. Avoid contact with cl fabrics, plastics and other materials, as it may cause damage. **Side-effects:** Some mild, transient irritation may occur, but in cases of more severe irritation or inflammation, treatment should be discontinued. Bazu and Bazuka Extra Strength Gel are highly flammable – Keep away from flames. Store at room temperature, not exceeding 25°C. Keep all medicines out of the reach of children. FOR EXTERNAL USE **Legal Category:** P **Packs:** Bazuka Gel (PL0173/0161) – 5g RSP £4.95 (£4.21 exc. VAT). Bazuka Extra Strength Gel (PL0173/0154) – 5g RSP £5.75 (£4.89 exc. VAT).